CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. If available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12 DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐	☒	☐

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47851

CERTIFICATE OF DEATH.

49 E 47851

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Low ST., 5-8 WARD)

2-FULL NAME Frank Raimondi

(a) RESIDENCE NO. 1102 Low ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Beatrice Wallbillick

6 DATE OF BIRTH (month, day, and year) January 10-1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
39	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Luciano Raimondi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Silvestri

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Beatrice Wallbillick

(Address) 204. N. Madeira St.

15 Filed JUL 23 1929, 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22- 1929

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to July 22, 1929, that I last saw him alive on July 22, 1929, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung (primary)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June 4/29

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

7/23, 1929 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 24, 1929

20 UNDERTAKER Geo J Ruth ADDRESS 1735 Harford ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47852

CERTIFICATE OF DEATH

89

E 47852

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 773 Furrow ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Holmes

(a) RESIDENCE NO. 773 Furrow ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced. HUSBAND of (or) WIFE of William Holmes

6 DATE OF BIRTH (month, day, and year) — — 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Neuddemand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. H. C. Carlson

(Address) 773 Furrow St

15 FILED JUL 23 1928 HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21/24

17 I HEREBY CERTIFY, That I attended deceased from July, 1927, to July 21, 1924 that I last saw h alive on July 21, 1924 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

1 Coronary Occlusion & Toxemia

(duration) 2 yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

1924 (Address) 7021 N. Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	7/25 1924
20 UNDERTAKER J. F. Lahey & Sons	ADDRESS 1318 Light St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47853

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

E 47853

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 Robert St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chas E. Dymby

(a) RESIDENCE NO. 552 Robert St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (Write the word) Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Ethel Johnson

(Address) 552 Robert St

Filed JUL 24 1928 19 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 28

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1928, to July 21, 1928

that I last saw h... alive on July 21, 1928

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) Harold Hastings, M. D.

July 22 (Address) 1111 Mt Ver Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 7-23 1928

20 UNDERTAKER Dennis Eanton

ADDRESS 916 Pa Ave.

Important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Blks.

E 47854

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47854

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Ryan

(a) RESIDENCE NO. Millwood - Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of: Singer

6 DATE OF BIRTH (month, day, and year): 4/9/70

7 AGE — Years: 59 — Months: 3 — Days: 14 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Graduate Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): H&B

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va —

PARENTS

10 NAME OF FATHER: Joseph Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va —

12 MAIDEN NAME OF MOTHER: Lucy McCormick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va —

14 Informant: Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 23, 1929, that I last saw h[illegible] alive on July 23, 1929, and that death occurred, on the date stated above, at 4.54 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, benign
Pulmonary embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Removal of tumor Date of July 20, 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. R. Trimble, M. D.

July 23 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Berryville Va — DATE OF BURIAL: July 24 1929

20 UNDERTAKER: John Merrick — ADDRESS: 2008 Orleans

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47855 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47855**

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. 8416

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Linsenbigler

(a) RESIDENCE NO. 2530 E. Hoffman st. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitress

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Joseph Fetterman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Emma Fetterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Hospital Records
(Address)

Filed JUL 24 1929 C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 25, 19 29, to July 21, 19 29, that I last saw her alive on July 21, 19 29 and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) [signature] M. D.

7-22 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. P. Laurel Cem	7/24/29
19a UNDERTAKER: Joseph Owens	ADDRESS: 24 Bway

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47896 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47896

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 n. madeira ST. 710 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME william Davis

(a) RESIDENCE No. 615 N. Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Mary Pankret

(Address) 615 N Madeira St

15 Filed JUL 24 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929 to July 23, 1929.

that I last saw h[illegible] alive on July 23, 1929

and that death occurred, on the date stated above, at 11 05 a m

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physical

What test confirmed diagnosis?

(Signed) [illegible] M. D.

July 24 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL July 26 1929

UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

BEFORE CAUSE OF DEATH is properly classified, Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47857 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47857

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4319 La Salle Ave. S. 26-42 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Huber

(a) RESIDENCE No. 4319 La Salle Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs mos ds How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Huber

6 DATE OF BIRTH (month, day, and year) June 30-1889

7 AGE Years 40 | Months | Days 22 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George P. Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Spierlyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary C. Huber (Address) 4319 La Salle Ave

JUL 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1929

17 I HEREBY CERTIFY, That I attended deceased from June 5. 1929, to July 22, 1929, that I last saw h[illegible] alive on July 22, 1929, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Uraemia

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs mos ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? [illegible]

Was there an autopsy? [illegible]

What test confirmed diagnosis?

(Signed) Claude Jones M. D.

July 23 1929 (Address) 4316 Ingraham Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

UNDERTAKER Leonard J. Ruck

DATE OF BURIAL July 25 1929

ADDRESS 6405 Loftus Ave. Halcott Cor.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH statement of ACCURATE and COMPLETE information on back of certificates.

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47858

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47858

91-002

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Frankfort E Radecke St., (Ward) 42

2-FULL NAME John B. S Stiefel

(a) RESIDENCE NO. Frankfort & Radecke St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louisa Stiefel

6 DATE OF BIRTH (month, day, and year) Aug-10-1847

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
81	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Stiefel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Englehardt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Margaret Stiefel
(Address) Frankford & Radecke

15 Filed ... 19... C. HAMPSON JONES, M. D.
Registrar

UL 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ... yrs. 1 mos. ... da.

CONTRIBUTORY (Secondary) Senility

(duration) ... yrs. 1 mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. C. Hades, M. D.

19 (Address) 143 W Read

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	7-26 1929
20 UNDERTAKER L. J. Cook	ADDRESS 6403 Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

146 E 47859

1—PLACE OF DEATH Franklin Square Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.) Balto ST., 5-8 (WARD) A.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carmella Russo

(a) RESIDENCE NO. 157 N Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Angelo Russo

6 DATE OF BIRTH (month, day, and year) April 3, 1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmela Franck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed JUL 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23-29

17 I HEREBY CERTIFY, That I attended deceased from 7-17-, 1929, to 7-23, 1929, that I last saw h alive on 7-23, 1929, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Miscarriage. about 8 week gestation -

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Peritonitis -

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-20-29

Was there an autopsy? no

What test confirmed diagnosis? Clinical -

(Signed) S. Drucker M. D.

7-27, 1929 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 25 1929
20 UNDERTAKER Frank T. Bradley	ADDRESS 146 Ashland Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47860

CERTIFICATE OF DEATH

28

E 47860

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 N. Patterson Park Ave ST. (or WARD)

2—FULL NAME Gertrude F. Kernan

(a) RESIDENCE NO. 1531 N. Patterson Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 11 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): Aug. 8 1918

7 AGE — Years: 10 | Months: 11 | Days: 14 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Bernard P. Kernan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah A. Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: M. Bernard P. Kernan

(Address) 1531 N. Patterson Park Ave.

15 Filed 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1929

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 22, 1929, that I last saw alive on July 22, 1929, and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Malnutrition — epilepsy

(duration) 10 yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wm. H. Perkins, M. D.

(Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 25 1929

20 UNDERTAKER: Henry Hoen Sons Inc. — ADDRESS: 1301 E Eager St

Important. See instructions on back of certificates.

Spec.—3-29-28—L. F. S.—500 Bks.

E 47861 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47861

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Joseph's Hospital REGISTERED NO. 28-65 -001

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thelma B. Brooke

(a) RESIDENCE NO. 5023 Wetherville Rd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 21, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Walter A. Brooke

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lula E. Cross

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mr. Walter A. Brooke
(Address) 5023 Wetherville Road

15 Filed ..., 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23-1929

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to July 23, 1929.

That I last saw h[illegible] alive on July 23, 1929

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever -

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) [illegible], M. D.

7/23 19[illegible] Broadway Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery — DATE OF BURIAL July 25 19 29

20 UNDERTAKER [illegible] — ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

E 47862

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47862

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 49

CITY OF BALTIMORE: (No. 207 W. Lanvale ST., 11-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matilda Leatherman

(a) RESIDENCE NO. 207 W. Lanvale ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Abraham Leatherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Mrs J. H. Beam

(Address) 4634 Kate Ave

Filed JUL 24 1929 C. HAMPSON JONES, M. D. Registrar

Date

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1922, to July 23, 1929, that I last saw h alive on July 22, 1929 and that death occurred, on the date stated above, at abt 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer (abdominal - origin of organ of origin undetermined)

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) ascites

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam. & Surg.

(Signed) Geo Abercrombie M. D.

July 24, 1929 (Address) 1112 Eager St. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Keyser W. Virginia	July 25 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47863 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47863

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 826 N. Fulton St. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Amelia Warkmeister

(a) RESIDENCE NO. 826 N. Fulton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Warkmeister

6 DATE OF BIRTH (month, day, and year): Sept 17 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Herman Bicky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Lorenz Kronthyer

(Address) 36 Hoodage Ave

15 JUL 24 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 29

17 I HEREBY CERTIFY, That I attended deceased from April 12 1928 to July 22 1929 that I last saw her alive on July 22 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of brain

(duration) Several months yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Axilla.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray etc

(Signed) M. L. Ingram, M. D.

19 (Address) 2439 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	19
20 UNDERTAKER: William Cook	ADDRESS: 1217 St Paul

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47864 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47864**

CERTIFICATE OF DEATH

137

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 3-5 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Pohle

(a) RESIDENCE NO. 1010 Stile ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman E Pohle

6 DATE OF BIRTH (month, day, and year) Jan 26 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Ignacius Winter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Winter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Herman E Pohle

(Address) 1010 Stiles St

15 Filed JUL 24 1929 HAMPSON JONES, M.

By H. Adler Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 23, 1929, that I last saw her alive on July 23, 1929 and that death occurred, on the date stated above, at 7.25 A. m.

The CAUSE OF DEATH* was as follows:

Ovarian cyst

(duration) about yrs. mos. ds.

CONTRIBUTORY (Secondary) Purulent Peritonitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-10-29

Was there an autopsy? Yes

What test confirmed diagnosis? Not definitely confirmed grossly.

(Signed) J. Leyba M. D.

7/23 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mm Cathedral	7/25 1929
20 UNDERTAKER	ADDRESS
D. M. Cook	1217 St Paul St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47865

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 E 47865

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West. Balto. Gen. Hosp. (Ward) 14-59

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kathleen Heathcote

(a) RESIDENCE NO. 2309 Riverton Rd. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (~~Wife~~ of) or) WIFE of Maurice V. Heathcote

6 DATE OF BIRTH (month, day, and year) June 15 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	46.	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Eyring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Virginia C. Heathcote
(Address) 2309 Riverton Road

15 C. HAMPSON JONES, M. D.
Registrar

7 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 23 1929.

17 I HEREBY CERTIFY, That I attended deceased from 7/13/1929, to 7/23/1929, that I last saw her alive on 7/23/1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Fibroid of Uterus 3 yrs
Chronic Nephritis 1 yr

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cystitis (duration) yrs mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) F. C. Hodges, M. D.

(Address) West. Balto. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem.	July 25 1929

20 UNDERTAKER Josiah Ziffer ADDRESS 1600 Ft. Wash. Ave

CAUSE OF DEATH in plain terms. Abbreviations not allowed. ATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Ems.

E 47866

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 47866

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 12-19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Inez. Dickerson

(a) RESIDENCE NO. 1510 Brentwood Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fmal	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) Oct 27-1924

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	4	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) [illegible] S. C.
(State or country)

PARENTS

10 NAME OF FATHER Wm Dickerson

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Lock

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Julia Dickerson
(Address) Lincoln Med.

15 Filed JUL 24 1929 16 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon, and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1510 Brentwood Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) H. C. Jones, M. D.

July 22 19 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md.	7/24/29
20 UNDERTAKER	ADDRESS
Geo. H. Holland	1631 Druid Hill Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—MAT—500 Blks.

E 47867

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47867.

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 Plateau Ave ST. 28-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Burman

(a) RESIDENCE NO. 3503 Plateau Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Geo. W. A. Burman

6 DATE OF BIRTH (month, day, and year): Nov 6 - 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
57	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Glover

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Clara Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Johnny Everson

(Address): 3503 Plateau Ave

15 C. HAMPSON JONES, M.D. Registrar

JUL 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1929

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to July 24, 1929, that I last saw h... alive on July 24, 1929, and that death occurred, on the date stated above, at 12.05 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chr. Valvular Heart Disease (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) Paul Brown, M. D.

(Address) 1663 N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Pauls Druid Hill Park — DATE OF BURIAL: 7-26 1929

UNDERTAKER: Mrs Chas A G Robb — ADDRESS: 2327 Edmondson

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important! See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47868

Louis Strunz.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47868

CERTIFICATE OF DEATH

12-9

1—PLACE OF DEATH

REGISTERED NO. 25-32

CITY OF BALTIMORE: (No.) 2900 Walbrook (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Strunz

(a) RESIDENCE NO. 2900 Walbrook ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Clara E. Strunz

6 DATE OF BIRTH (month, day, and year) Jan 1 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	6	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER August Strunz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Philippine Tetmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wife
(Address)

15 Filed JUL 24 1929 C. HAMPSON JONES, Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-29

17 I HEREBY CERTIFY, That I attended deceased from July 12 1929 to July 22 1929

that I last saw h... alive on July 22 1929

and that death occurred, on the date stated above, at 7 A.M. P.M.

The CAUSE OF DEATH* was as follows:

1. Myocarditis (acute)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Augustus R. Von Schulz M.D.

(Address) 536 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 7-25 1929

UNDERTAKER E. B. Hurle

ADDRESS 115 W. Mt. St.

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47869 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47869**

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Joseph Hospital REGISTERED NO. 27448

CITY OF BALTIMORE: (No. Caroline & St.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby girl Larkin

(a) RESIDENCE NO. 511 Mulberry St. WARD 4th Cube.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. L. Larkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant C. L. Larkin
(Address) 1100 Bonaparte Ave

15 Filed JUL 24 1929 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23rd-29

17 I HEREBY CERTIFY, That I attended deceased from 7-14-29, 19..., to 7-23-29, 19...,
that I last saw h alive on 7-23-29, 19...
and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) W B Hunter M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 26th, 29.
20 UNDERTAKER Fred O. Krause & Sons	ADDRESS 703 Hanover St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47870 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47870

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Edgewood San ST. 6 11 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella. Irene. Roberts.

(a) RESIDENCE NO. 140 N Ellwood ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Thomas Roberts

6 DATE OF BIRTH (month, day, and year) Nov 19-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Magaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Louisa Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Thomas Roberts

(Address) 140 N Ellwood Ave

JUL 24 1929

Filed C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to July 22, 1929, that I last saw h alive on July 22, 1929, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Chron. Interstitial Nephritis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Hons, M. D.

July 22 1929 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 25 1929
20 UNDERTAKER	ADDRESS
Jas. C. Miller & Son	2338 Eastern Ave

IMPORTANT—Should be carefully supplied. Note that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47871 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47871**

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412. N. Greene ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salvatore Brocato

(a) RESIDENCE NO. 412. N. Greene ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rosa Liberto

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	66.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Rosario Brocato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Liberto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Pietro Liberto

(Address) 412. N. Greene St.

15 Date JUL 24 1929 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1929 to July 23, 1929

that I last saw him alive on July 23, 1929

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerotic Cardio-Vascular-Renal Disease.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. A. Tammariello, M. D.

, 19 (Address) 306 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery.	July 25 1929
UNDERTAKER	ADDRESS
George F. Rust	1735 Harford a

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 ✓ E 47872

REGISTERED NO.

1—PLACE OF DEATH St Joseph's Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Gardenr Dover ST. 27-44 WARD)

2—FULL NAME Martha Hartman

(a) RESIDENCE NO. 2809 Montebello Terrace WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ John Hartman

6 DATE OF BIRTH (month, day, and year) July 20 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	—	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbia, Pa.

PARENTS

10 NAME OF FATHER Richard Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Elizabeth Hoover.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mr. John Hartman

(Address) 2809 Montebello Ter.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to July 23, 1929

that I last saw her alive on July 23, 1929

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of July 22, 1929

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Vincent Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL July 25 1929

20 UNDERTAKER Hornberger & Goods ADDRESS Md Edmondson

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47873

CERTIFICATE OF DEATH

22-30

E 47873

1-PLACE OF DEATH

City of Baltimore: (No. 415 W. Barre St. Street Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude Fisher.(C)

(a) RESIDENCE NO. 415 W. Barre St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married.

5a If married, widowed or divorced (or) WIFE of Seymore Fisher.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Jennie Fitzhugh.(C)
(Address) 415 W. Barre St.

15 Filed JUL 24 1929 C. HAMPSON-JONES, M. D. Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Enquiry

(Signed) Otto M. Reinhardt, M. D.

7/22, 1929 (Address) 617 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS JUL 24 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47874

CERTIFICATE OF DEATH

82 E 47874

1-PLACE OF DEATH

City of Baltimore: (No. Pier 7 Light St. Wharf. St., Ward) 23-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Garner.(C) or Barber(C)

(a) RESIDENCE NO. 988 S. Sharp St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
About 25	---------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Deck hand.
(b) General nature of industry, business, or establishment in which employed (or employer) Stmr. Piankatank.
(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Barber.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Emma ---------(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Ida Garner.(C) stepsister.
(Address) 988 S. Sharp St.

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

JUL 24 1929 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a wharf.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

(Address) 104 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. DATE OF BURIAL 19

20 UNDERTAKER Weaver Heath, ADDRESS

JUL 24 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47875

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 47875

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. 76-37 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Smith

(a) RESIDENCE NO. ? ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 3-21-72

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? 040

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Va.

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Va.

12 MAIDEN NAME OF MOTHER Betty Ann ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Va.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

Filed JUL 24 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21-1929.

17 I HEREBY CERTIFY, That I attended deceased from 7-10, 1929, to 7-21, 1929, that I last saw h... alive on 7-21, 1929 and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Nephritis, Fibrosis Aortic Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C.C. City

(Signed) Warren W. McLean M. D.

7/24, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	June 23 1929
UNDERTAKER	ADDRESS

Important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 47876

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 15 W. Lee St. St. 22-30 Ward)

2-FULL NAME William J. Jones. (O)

(a) RESIDENCE NO. 15 W. Lee St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, ~~WIFE~~ HUSBAND of (or ~~WIDOW~~) Rosetta Jones. (O)

6 DATE OF BIRTH (month, day, and year) March 24, 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	32	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER: Eldridge Jones. (O)

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Mary A. Johnson. (O)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Baltimore, Md.

14 Informant: Susie Jones. (O) sister.
(Address) 15 W. Lee St.

15 Filed JUL 24 1929, 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Syphilis.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Hospital Diagnosis.

(Signed) Otto H. Eichhardt, M. D.

7/24 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	7-24 1929
20 UNDERTAKER: Dennis Eardley	ADDRESS 916 E Pratt

Spec.—1-10-21—M&T—1500 Blks.

47877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 W. Baltimore S. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Schneider.

(a) RESIDENCE NO. 2301 W. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male.	white.	married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Magdalena Schneider.

6 DATE OF BIRTH (month, day, and year) June 6, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Austria - Hungary

PARENTS

10 NAME OF FATHER Nicholas Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Hungary.

12 MAIDEN NAME OF MOTHER Anna Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria Hungary

14 Informant (Address) Madgalena Schneider 2301 W. Baltimore St.

15 Filed JUL 24 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 22 1929, that I last saw h[illegible] alive on July 22, 1929 and that death occurred, on the date stated above, at 12.09 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage acute.

Hemiplegia left. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Arterial. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) James Graham Marston, M. D.

7-13 1929 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Cathedral

DATE OF BURIAL: 7/26 1929

20 UNDERTAKER: Edward Loulson.

ADDRESS: 2357 W. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47878

CERTIFICATE OF DEATH

159-002

E 47878

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2803 Berwick Av. ST., 27-43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothy M. Hild

(a) RESIDENCE NO. 2803 Berwick Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 22nd 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George A. Hild

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Marie Schrayhoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs. George A. Schrayhoff

(Address) 2803 Berwick Av.

Filed JUL 24 1929 JAMES H. JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to July 24, 1929

that I last saw h alive on July 23, 1929

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cyanosis Non closure Foramen ovale

Juvenile birth duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

July 24 1929 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery.	July 25 1929
20 UNDERTAKER	ADDRESS
Henry Hoech Sons, Inc.	1301 E Eager St

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47879

CERTIFICATE OF DEATH.

E 47879

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 927 N. 33rd St. 1351 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas J. Fincham.

(a) RESIDENCE NO. 927 N. 33rd St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May. 10/1928.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	2.	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Cleveland J. Fincham

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Berkley Co. Va.

12 MAIDEN NAME OF MOTHER Ethel Sullivan

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Balto Md.

14 Informant Cleveland J. Fincham

(Address) 927 N. 33rd St

15 Filed JUL 24 1929, 19____ C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24/29.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

(Coroner)

7/23, 19 29 (Address) 2072 Orland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden. Date of Burial: July 25/ 1929

20 UNDERTAKER: J. Whittesdame ADDRESS: 3307 Penn St

(If stillborn, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47880

CERTIFICATE OF DEATH

X 189 E 47880

1—PLACE OF DEATH

REGISTERED NO. 76-37

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mohamed Yusef

(a) RESIDENCE NO. Bedwell farms ST., Laurel, Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amina Yusef

6 DATE OF BIRTH (month, day, and year) Unknown

Years	Months	Days	If LESS than 1 day, hrs. or min.
abt 30 Unknown			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record.
(Address)

15 Filed JUL 24 1929, 19 H. MASON JONES, M. D.
Registrar

UL 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/29

17 I HEREBY CERTIFY, That I attended deceased from 7/9, 19 29, to 7/24, 19 29, that I last saw h-im alive on 7/24, 19 29 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Fractured pelvis.
Decubitus ulcers of back and Buttock

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Laurel Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) L. L. Lumpkin, M. D.

7/24, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Same Georgia Cemetery Pleasant View Cemetery	July 26 1929
20 UNDERTAKER Elwood M. Fisher	ADDRESS Laurel Md.

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47881
1-PLACE OF DEATH

CERTIFICATE OF DEATH. 117

E 47881
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home & Infirmary 4-45 WARD)

2-FULL NAME Charles Holm

(a) RESIDENCE No. 2712 Hugo Ave St. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Bernadine Holm

6 DATE OF BIRTH (month, day, and year) May 30. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10 NAME OF FATHER Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Bernadine Holm (Wife)
(Address) 2712 Hugo Ave

15 Filed JUL 24 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1929

17 I HEREBY CERTIFY, That I attended deceased from July 15 1929. to July 24 1929. that I last saw him alive on July 24 1929. and that death occurred, on the date stated above, at 12:35 a m.

The CAUSE OF DEATH* was as follows:
Appendicitis Acute Suppurative Peritonitis - (Generalized)

(duration) yrs. mos 8 ds.
CONTRIBUTORY (Secondary) - Bronchopneumonia
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home
Did an operation precede death? Yes Date of July 18. 1929
Was there an autopsy? - Yes
What test confirmed diagnosis? - Operation & Autopsy
(Signed) - James C. Bruce M. D.
(Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL July 26 1929

20 UNDERTAKER Henry Sander & Sons Inc. — ADDRESS Baltimore St & Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47882

CERTIFICATE OF DEATH

107-001

E 47882

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josiah Whittemore

(a) RESIDENCE NO. 1040 Homewood Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? _ yrs. _ mos. _ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer ?40

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Whittemore

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Ann ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) England

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed 7-24 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1929 to July 23, 1929

that I last saw him alive on July 23, 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

1 Anthracosis - an occupational disease

Questionable (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis and cardiac failure

Questionable (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no history obtained: the patient may have been a coal miner. The specimen microscopic sections

Did an operation precede death? no Date of

Was there an autopsy? Baltimore City Hospitals

What test confirmed diagnosis? Inspection of lungs and discovery of calcific infiltration about

(Signed) Marion M. Lee M. D.

7-24 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 25 1929
20 UNDERTAKER	ADDRESS
Henry Sander & Sons	Baltimore St & Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 91-002

E 47883

CERTIFICATE OF DEATH

E 47883

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST. 4 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Rannie

(a) RESIDENCE NO. (Usual place of abode) Highland Maryland ST. WARD

Length of residence in city or town where death occurred [illegible] yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Rannie

6 DATE OF BIRTH (month, day, and year) Aug 16 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Duncan Rannie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Hospital Record

(Address)

15 Filed JUL 24 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929.

17 I HEREBY CERTIFY, That I attended deceased from January 18, 1929. to July 23, 1929.

that I last saw him alive on July 23, 1929

and that death occurred, on the date stated above, at 9 45 p. m.

The CAUSE OF DEATH* was as follows:

Senile Forgetfulness (Left foot gangrene intermittent claudication)

(Duration) yrs. 9 mos. ? ds.

CONTRIBUTORY (Secondary) Cardiac Failure ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes. Date of 3/2, 7/4, 7/9

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) David Penner, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catonsville Md	7/26 1929

20 UNDERTAKER Fayette Funeral Service ADDRESS Fayette

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47884

CERTIFICATE OF DEATH.

162 E 47884

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S. CHESTER STREET St. 1-3 WARD)

2-FULL NAME Joseph ONHEISER

(a) RESIDENCE NO. 117 S. CHESTER STREET ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	SINGLE

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July.23.1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 24 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frank Onheiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Miskiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Father, Frank Onheiser
(Address) 117 S. Chester Street

15 Filed JUL 24 1929 19 H. HAMPSON JONES, M. D. (Registrar)
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July.23.1929

17 I HEREBY CERTIFY, That I attended deceased from July 23, 19 29, to July 23, 19 29, that I last saw him alive on July 23, 19 29, and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:

ACTALECTASIS

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Kopanek M. D.

, 19 (Address) 801 N. [illegible] AVENUE

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: July 27 1929

20 UNDERTAKER: John M Weber — ADDRESS: 704 E Chester St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47885

CERTIFICATE OF DEATH.

E 47885

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 N. Caroline St. 10-13 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Wilson

(a) RESIDENCE NO. 806 N. Caroline ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, ~~or Divorced~~ (write the word)
M	Col	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of or) WIFE of Sarah. Wilson

6 DATE OF BIRTH (month, day, and year) May 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	71	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Nelson Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant William H. Wilson Jr. (Address) 2231 Edmondhill ave.

15 Filed JUL 24 1929 J. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929

17 I HEREBY CERTIFY, That I attended deceased from July 15 1929 to July 23 1929 that I last saw him alive on July 23 1929 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 2 yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Calvin B. LeCompte, M. D.

19 (Address) 514 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sanel Ldm — DATE OF BURIAL 7-26 1929

20 UNDERTAKER Mrs. J. B. Locke — ADDRESS 1302 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47886 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47886
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eldrey McArgo

(a) RESIDENCE NO. 1604 Etting ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bro
(Address)

Filed 7-4 1929 H. HANSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/23 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1929, to 7/23/, 1929.
that I last saw he alive on 7/23/29, 19,
and that death occurred, on the date stated above, at 4 05 P m.
The CAUSE OF DEATH* was as follows:
Tuberculosis Meningitis

(duration) yrs. about 21 mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) George McDonald M. D.
, 19 (Address) Provident Hosp'l,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 7/25/29

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1601 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47887

CERTIFICATE OF DEATH

66 E 47887

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 733 W. Lexington St. Ward)

2-FULL NAME Margaret B. Post

(a) RESIDENCE NO. 733 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Balto Police Dept.
(Address)

15 Filed JUL 24 1929 19 HARRY H. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Gilbert M. D.

7/24. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland, Md.	July 24 1929
20 UNDERTAKER	ADDRESS
Henry W. Meyerson	800 N. Calvert St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—500 Blks.

E 47888 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47888**

CERTIFICATE OF DEATH. 109-002

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 30 E. 26th St. W. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Neary Counselman

(a) RESIDENCE NO. 30 E. 26th St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28th 1928

7 AGE: Years 1 | Months 3 | Days 26 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Wm B. Counselman

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Eleanor B. Neary

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Wm B. Counselman

(Address) 30 E. 26th St.

Filed JUL 25 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/1/29, 19..., to 7/24/29, 19..., that I last saw h[illegible] alive on 7/24/29, 19..., and that death occurred, on the date stated above, at 8:54 m.

The CAUSE OF DEATH* was as follows:

"Septic Sore Throat"

(duration) 1 yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Throat Cult

(Signed) Howard Dess, M. D.

7/24/29 (Address) 321 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date 7/25 1929

20 UNDERTAKER Chas F. Fraud & Son Address 1180 Mt Royal Ave

Physician should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

2E 47889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 90

E 47889

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., WARD)

2—FULL NAME Henry M. Staats

(a) RESIDENCE NO. Chillicothe - Ohio.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Louise S—

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N-Y

PARENTS

10 NAME OF FATHER Henry Staats

11 BIRTHPLACE OF FATHER (city or town) (State or country) N-Y—

12 MAIDEN NAME OF MOTHER Eliz - Newman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N-Y

14 Informant Records—

(Address)

15 Filed JUL 25 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25-29

17 I HEREBY CERTIFY, That I attended deceased from Sept-24, 1928, to July 25-, 1929 that I last saw h[illegible] alive on July 25- 1929 and that death occurred, on the date stated above, at 7 25 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis, hypertension, terminal condition following chronic pyogenic infection

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) cachexia and decubitus ulcers (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Ruth E Fairbanks, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D. C.	July 26 19 29
UNDERTAKER	ADDRESS
Lewis H. Redmond	1532 Hollins St

important: See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47890

CERTIFICATE OF DEATH

E 47890

90

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah Warrington

(a) RESIDENCE NO. 810 Woodward ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. ? How long in U. S., If foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): ? Pennsylvania

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Unknown

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed JUL 25 1929 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929 to July 23, 1929, that I last saw her alive on July 23, 1929 and that death occurred, on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Chronic Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Marvin M. McClean, M. D.

7-24, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

UNDERTAKER: Wm Cook

DATE OF BURIAL: 7/25 1929

ADDRESS: 1211 Light St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47891

CERTIFICATE OF DEATH

74-001

E 47891

1—PLACE OF DEATH

CITY OF BALTIMORE. ONo. 2654 Frederick St. 69 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas J Sommer

(a) RESIDENCE NO. 2654 Frederick St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Eliz Sommers

6 DATE OF BIRTH (month, day, and year): May 23 1855

7 AGE — Years: 71 | Months: 2 | Days: | If LESS than 1 day.....hrs. or.....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Moulder

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Wm Tyson

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Samuel Sommers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Anna Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs Grace Tucker

(Address) 2654 Frederick St

15 Filed JUL 25 1929, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23-29

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 23, 1929.

That I last saw him alive on July 23, 1929.

and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

Cerebral Hemorrhage (duration) yrs. mos. 4 ds.

(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Augustine S. Vonderschmitt

(Address) 530 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Presbyterian Trans

DATE OF BURIAL: 7/26 1929

20 UNDERTAKER: Wm Cox

ADDRESS: 12-17 N Paca

important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Bks.

E 47892

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47892

16-002

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 N Wallard ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Wright

(a) RESIDENCE NO. 1516 N Wallard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Fred Right

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Pearl Wallard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Fred Right

(Address) 1516 N Baller

15 Filed JUL 25 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1929

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to July 24, 1929

that I last saw h alive on July 24, 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Otis Medical E worked Toxemia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Entero Colitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R T Young, M. D.

July 24, 1929 (Address) 1429 E Monument St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury

DATE OF BURIAL July 25 1929

20 UNDERTAKER John W Henderson

ADDRESS 1422 E Monument

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47893 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47893

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2542 W. Lanvale St. ST. 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Rowe

(a) RESIDENCE NO. 2542 W. Lanvale St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 3 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank W. Rowe

6 DATE OF BIRTH (month, day, and year) Mar. 30 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Carey Southcomb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Annie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Family

(Address)

15 Filed JUL 25 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-29

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1929, to July 22, 1929, that I last saw h[illegible] alive on July 22, 1929, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Generalized arteria Sclerosis Chronic Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) W. Lemke, M. D.

July 24 1929 (Address) 2901 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	7/25 1929
20 UNDERTAKER M. H. Tews Mc Cully	ADDRESS 1308 Ferd.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47894

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 E North Ave ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Seisendoffer

(a) RESIDENCE NO. 710 E North Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of Georgia A. Seisendoffer

6 DATE OF BIRTH (month, day and year) Dec. 23 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va

PARENTS

10 NAME OF FATHER Wm. Seisendaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E. Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harry F. Seisendaffer
(Address) 102 Lexington St

15 Filed. C. HAMPSON JONES, M. D. Registrar
JUL 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929

17

I HEREBY CERTIFY, That I attended deceased from 7-22, 1929, to 7-23, 1929, that I last saw him alive on 7-23, 1929, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. J. Bamberger, M. D.

7/25, 1929 (Address) 1928 N. Eutaw 3 Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	July 25 1929
20 UNDERTAKER Wm J Tuckner & Sons	ADDRESS N. Y Pa

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47895

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47895

CERTIFICATE OF DEATH

1887-02

1-PLACE OF DEATH

City of Baltimore: (No. West Balto General Hosp. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie L Way

(a) RESIDENCE NO. 3503 Edmondson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas D Way

6 DATE OF BIRTH (month, day, and year) Feb-14-1898

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
30	5	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Fred C Heine

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lena Blunt

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Geo. D. Way
(Address) 3503 Edmondson Ave

15 Filed JUL 25 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract base of skull due to running into side of moving auto and that her death was accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Was at home of 3503 Edmondson Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D. Mann M. D.

7/29 1929 (Address) 1939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 26 1929
20 UNDERTAKER	ADDRESS
H. B. Hilgart	1850 N. Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47896

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47896

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 S. Payson ST. 20-27 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma C. Eccleston

(a) RESIDENCE NO. 102 S. Payson ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 8 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 22 1849

7 AGE: Years 79 | Months 8 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: O H S

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Eccleston

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Finlayson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs Lillie M. Price

(Address) 102 S. Payson St

15 Filed JUL 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 29

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 24, 1929, that I last saw her alive on July 23, 1929, and that death occurred, on the date stated above, at 2:25 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) Ethelbert Henning M. D.

7/25, 1929 (Address) 2000 Hollins St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 26 1929

20 UNDERTAKER: H. Wayland — ADDRESS: 850 W. Baltimore St

important. See instructions on back of certificates.

E 47897

E 47897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH: CITY OF BALTIMORE ~~South~~ South Baltimore General Hospital

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Spector

(a) RESIDENCE NO. 3510 Auchentorolly Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. How long in U. S., if foreign birth 48 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha S. Spector

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Dr. Nathan Spector

(Address) 1426 Light Street

15 Filed JUL 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-29

17 I HEREBY CERTIFY, That I attended deceased from 7-24 1929 to 7-25 1929 that I last saw him alive on 7-25 1929 and that death occurred, on the date stated above, at 12.20 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Chronic nephritis, Diabetis mellitus

Uncorrected Hernia (duration) yrs. mos. ? da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-24-29

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Lankowitz M. D.

(Address) South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	July 25 1929
20 UNDERTAKER	ADDRESS
Jack Laurs	1439 E Baltimore St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47898

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47898

CERTIFICATE OF DEATH.

131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (Ward) 6-9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Mouton

(a) RESIDENCE NO. 1515 E. Fayette St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) V.a

PARENTS

10 NAME OF FATHER Levi Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) V.a

12 MAIDEN NAME OF MOTHER Sadie Diarge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) V.a

14 Informant Marscline Jackson

(Address) 1422 Silver Court

15 Filed JUL 25 1929 C. HAMPSON JONES, M. D. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-1929

17

I HEREBY CERTIFY, That I attended deceased from 7-3-, 1929, to 7-22-, 1929,

that I last saw him alive on 7-22-, 1929,

and that death occurred, on the date stated above, at 7 10 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism
Multiple abscess kidney
Mesenteric Thrombosis

(duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) Intestinal tuberculosis

(duration) yrs mos 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

(Address) Provincetown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL July 25 1929

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47899 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47899

66

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospts

CITY OF BALTIMORE: (No. Balto Md. ST. 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andy Godzeski

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md.

15 Filed JUL 25 1929 C. HAMPSON JONES, M. D. By Hasse

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17-29

17 I HEREBY CERTIFY, That I attended deceased from 2-27, 1929 to 7-17, 1929

that I last saw him alive on 2-16, 1929

and that death occurred, on the date stated above, at 8.10 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Starvation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis

Depression (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry Goldman M. D.

7/17, 1929 (Address) Balto City Hospts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	7/25 1929
20 UNDERTAKER John J. Fahey & Sons	ADDRESS 1318 Light St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47900 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47900

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 Hamburg St. 25-72 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Dorsey

(a) RESIDENCE NO. 228 Hamburg ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	54	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frankford Md

PARENTS

10 NAME OF FATHER William Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Mary Scott
(Address) 228 Hamburg St

Filed JUL 25 1929 C. HAMPSON JONES, Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to July 24, 1929, that I last saw her alive on July 20, 1929, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. W. Fowler M. D.

July 29 1929 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL July 27 1929

UNDERTAKER — ADDRESS

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47901

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 N Green ST. 4-25 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonino Aquila

(a) RESIDENCE NO. 222 N. Green ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angela Aquila

6 DATE OF BIRTH (month, day, and year) Feb 15-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	5 4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Ignazio Aquila

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Ignazia Luzzo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Aquila

(Address) 408 N. Green St.

Filed JUL 25 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1929, to July 23, 1929, that I last saw him alive on July 23, 1929 and that death occurred, on the date stated above, at 11 35 P m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DiStefano M. D.

July 29 1929 (Address) 407 N. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 26 1929

UNDERTAKER: Geo. J. Reuth — ADDRESS: 1735 Harford Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47902

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47902

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp. 145-21 St. 129 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Bailey

(a) RESIDENCE NO. 1405 Eastern ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
35	36	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Neme of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Bill Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wife
(Address)

15 Filed Dec. 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/21 1929 to 7/24 1929 that I last saw him alive on 7/24 1929 and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypertension Cardio Vascular Renal Disease

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) George W. McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct — DATE OF BURIAL July 26 1929

20 UNDERTAKER J. L. Brown & Son — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

29-001 E 47903

1-PLACE OF DEATH

City of Baltimore: (No.) Md Gen. Hosp. (St.) 25-64 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Clifton Gettier Jr.

(a) RESIDENCE NO. 5325 Wesley Ave., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28 1915

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
14	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John Clifton Gettier

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Holtzman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant J. Clifton Gettier
(Address) 5325 Wesley St

Filed JUL 25 1929 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to his death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident (July 4th) Typhoid

Tetanus

(duration) yrs. mos. 11 da.

CONTRIBUTORY (Secondary) Pistol wound of Hand

(duration) yrs. mos. 20 da.

18 Where was disease contracted If not at place of death? home

Did an operation precede death? yes Date of July 13

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) July 24th 1929 Hedrick M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	July 26 29

20 UNDERTAKER Richard Poe ADDRESS 123 Reformer Future

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 47904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59-002 E 47904

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 703 S Bond St. St. 2-4 Ward)

2-FULL NAME Anna Kasprzak

(a) RESIDENCE NO. 703 S Bond St. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wladyslaus Kasprzak

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Brolinska

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Poland

14 Informant Wladyslaus Kasprzak

(Address) 703 S. Bond St.

Filed JUL 25 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1929

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to. her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Liv.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ___ yrs. ___ mos. ___ ds.

Filed 7/25/29 J C Gladis, M. D.

(Coroner)

19 ___ (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial July 25 1929

20 UNDERTAKER John M Weber ADDRESS 101 a Chester

tion should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Stated EXACTLY. PHYSICIANS should state CAUSE
erly classified. Exact statement of OCCUPATION is
ficate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47905 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47905

129

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Edmondson av. ST. 46-71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Wisnig

(a) RESIDENCE NO. 4000 Edmondson av. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred all lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Wisnig

6 DATE OF BIRTH (month, day, and year) May 5, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Georg Wisnig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Bernheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Josephine Wisnig

(Address) 4000 Edmondson av.

JUL 25 1929

Filed ....., 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to July 23, 1929, that I last saw him alive on July 23, 1929 and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

chronic Brights disease

about 1 year (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No chem. & micros. tests.

What test confirmed diagnosis? Physical signs & symptoms and A

(Signed) L. F. Shemwell, M. D.

July 24, 1929 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 26 1929
20 UNDERTAKER	ADDRESS
George Sindt	1732 Hollins

Important. See instructions on back of certificate. Fill in plain terms, so that it may be plainly read by the printer. Use black ink or indelible pencil. Do not abbreviate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47906 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47906

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4101 Bonner Road ST. 15-65 129 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora R. Anderson

(a) RESIDENCE NO. 4101 Bonner Road. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5[illegible] yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles R. Anderson

6 DATE OF BIRTH (month, day, and year) Aug. 5, 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5[illegible]	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Oliver Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Delilah Smith,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14

Informant Mrs. Mildred Appel

(Address) 4101 Bonner Rd.

Filed DEC 5 1929 19 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929.

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to July 23, 1929, that I last saw h[illegible]er alive on July 17, 1929 and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Sudden death. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis with hyper-tension. (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Maurice E. Shamer, M. D.

7/24/ 1929 (Address) 3300 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	July 26 1929
20 UNDERTAKER George J. Smith	ADDRESS 453 Hollins

Use Black ink—plain letters, so that it may be plainly legible when photographed. Be sure to fill in all items. Every item is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47907 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47907

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Fremont St. 17-7b WARD)

2-FULL NAME Abraham Wise

(a) RESIDENCE NO. 511 N Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	8		

8 OCCUPATION OF DECEASED,

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma K Wise (Address) 511 N Fremont

15 Filed JUL 25 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/23/29 19

17 I HEREBY CERTIFY, That I attended deceased from 7/1 29, 19 to 7/23/29 19,

that I last saw h— alive on 7/23/29, 19,

and that death occurred, on the date stated above, at 8:04 m.

The CAUSE OF DEATH* was as follows:

Carcinoma 4 yrs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of Jan 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Long, M. D.

7/25/1929 (Address) 1104 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	July 26 1929
UNDERTAKER Charles H Keehner	ADDRESS 153 L Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

re E 47908

170 E 47908

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH In Woods near Elliott Drive & Franklintown Rd 11-25 (Ward)

City or [illegible] (No.)

2-FULL NAME Maurice Skolkem

(a) RESIDENCE NO. 122 N Fremont St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 41 | Months — | Days — | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lawyer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Russia
(State or country)

PARENTS

10 NAME OF FATHER Max Skolkem

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Betty Lowenthal

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant: Fred Skolkin
(Address) Passaic N.J.

15 Filed [illegible] 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) about June 15th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to h[illegible] death on the day stated above.
The CAUSE OF DEATH* was as follows:

Hemorrhage due to fractured wound of Head
Suicide
(duration) yrs. Sudden

CONTRIBUTORY (Secondary)

18 Was [illegible] (duration) yrs. mos. ds.
[illegible] In woods near Elliott Drive and Franklintown Rd.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) H. Leslie Corner. M. D.
July 24th 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cemetery — DATE OF BURIAL July 27 1929

20 UNDERTAKER: A Lerman Bro — ADDRESS 1112 Bultimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47909 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

33

E 47909

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. John ST., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Butta

(a) RESIDENCE NO. 305 S. High St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John L Butta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Virginia Cherigo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

11 Informant Mrs. Mary Cherigo

(Address) 141 N Linwood Ave

15 Filed JUL 25 1929 H. HARROW JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to July 23, 1929, that I last saw h~~im~~ alive on July 23, 1929 and that death occurred, on the date stated above, at 4-30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of mesenteric and retroperitoneal glands

(duration) 1 yrs mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-22-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operative

(Signed) J. J. Leyko, M. D.

7/23, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 27, 1929

20 UNDERTAKER Frank V. Pupitone — ADDRESS 818 E, Baltimore

IMPORTANT—Physicians are required by law to report deaths promptly. Fill out all items, so that it may be prepared for permanent record. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47910

CERTIFICATE OF DEATH

57

E 47910

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Whitfield Rd ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Everly

(a) RESIDENCE NO. 12 Whitfield Rd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or), WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Servant Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wilmington N.C.

PARENTS

10 NAME OF FATHER Wm Everly

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Dr Gordon Wilson

(Address) 12 Whitfield Rd

15 Filed JUL 25 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25-1929

17

I HEREBY CERTIFY, That I attended deceased from [redacted] 30, 1925, to July 24, 1929.

that I last saw h[redacted] alive on July 24- , 1929

and that death occurred, on the date stated above, at about 10 m.

The CAUSE OF DEATH* was as follows:

Empiema Pleuris

(duration) 0 yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) diabetes

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood & urine tests

(Signed) Gordon Wilson M. D.

, 19 (Address) 715 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 26 1929
20 UNDERTAKER and John O Mitchell Son	ADDRESS 1911 Eastern Ave

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

22743 E 47911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 54-003

E 47911

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. 7-9 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Painter Jr.

(a) RESIDENCE NO. Jacksonville ST., Fla - WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Baby

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/3/28

7 AGE — Years | Months: 7 | Days: 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Fla -

PARENTS

10 NAME OF FATHER Geo. S. Painter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fla -

12 MAIDEN NAME OF MOTHER Dorothy Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fla -

14 Informant: Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 - 29

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to July 25, 1929, that I last saw him alive on July 25, 1929, and that death occurred, on the date stated above, at 7.25 a. m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Trephine for possible brain abscess

Did an operation precede death? Yes Date of July 24, 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble M. D.

July 24 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jacksonville Fla — DATE OF BURIAL: 7/25/29

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Emory

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Best.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47912

REGISTERED NO. **E 47912**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 W Saratoga ST., 4-25-90 WARD)

2—FULL NAME Julia Beth

(a) RESIDENCE NO. 646 W Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) March 8th 69

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Rufus Foulkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Anna Taylor

(Address) 646 Saratoga st

15 Filed JUL 25 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23/29

17 I HEREBY CERTIFY, That I attended deceased from May 3 , 1929, to July 25 , 1929, that I last saw her alive on July 23 , 1929, and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Hyperthrophy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. N. Hatcher, M. D.

7/25, 1929 (Address) 1115 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery Cem DATE OF BURIAL July 26 1929

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47913

CERTIFICATE OF DEATH

161-001 ✓ E 47913

1—PLACE OF DEATH

REGISTERED NO. 1124

CITY OF BALTIMORE: (No. Md. Gen. Hosp ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Salter.

(a) RESIDENCE NO. ST., WARD Pikesville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 7-21-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				2 hrs. or 25 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Salter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pikesville Md.

12 MAIDEN NAME OF MOTHER Elizabeth Seamon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ridgeway N.C.

14 Informant Hospital Records.

(Address)

15 Filed JUL 25 1929, 19 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21-29

17

I HEREBY CERTIFY, That I attended deceased from 7.35 A.M. 7-21, 1929, to 10.35 P.M. 1929 7-21-29 that I last saw him alive on at 10.35 P.M. 7-21 1929 and that death occurred, on the date stated above, at 10.35 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity (Twin to child)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta Praevia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Lampkin M. D.

(Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
(Hoge)	
20 UNDERTAKER	ADDRESS

IMPORTANT: THIS CERTIFICATE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 47914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 47914 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 15 N. Fayette Ave St. 12-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Jones

(a) Residence No. 15 N. Fayette Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, Col | 5-Single, Married, Widowed, or Divorced. (Write the word.) Mar'd

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Martha Jones

6-DATE OF BIRTH (month, day and year) 1869

7-AGE. 58 yrs. mos. ds. If LESS than 1 day hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or Town) (State or Country) South Carolina

PARENTS

10-NAME OF FATHER Bill Jones

11-BIRTHPLACE OF FATHER (City or Town) (State or Country) South Carolina

12-MAIDEN NAME OF MOTHER Mattie Ward

13-BIRTHPLACE OF MOTHER (City or Town) (State or Country) South Carolina

14-Informant Bessie Jones

(Address) 15 N. Fayette Ave

15-Filed JUL 25 1929 HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 23 1929

17-I HEREBY CERTIFY, That I attended deceased from July 19 1929 to July 22 1929

that I last saw him alive on July 22 1929

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH was as follows: Intestinal Nephritis

Duration 2 Days mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? By examination

(Signed) P. Earle Chenoweth M. D.

July 25, 1929 (Address) 1534 Druid Hill Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Camden S. Carolina — DATE OF BURIAL: 7/26/ 1929

20-UNDERTAKER: Mrs Chas L. Bailey — ADDRESS: 1421 Jefferson St

Please fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47915 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47915**

CERTIFICATE OF DEATH 74-001

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 3215 Greenmount Ave ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Smith

(a) RESIDENCE NO. 3215 Greenmount ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura A Smith

6 DATE OF BIRTH (month, day, and year): Sept 2-1864

7 AGE: Years 64 | Months 10 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Massachusetts

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Brown

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Ireland

14 Informant: Laura A Smith

(Address) 3215 Greenmount

15 Filed ..... 19 .....

6 1929 Per C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25-29

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to July 24, 1929, that I last saw h— alive on July 24, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis agitans

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) G. J. Schubert, M. D.

July 29 1929 (Address) 632 Fairmount Ave Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westboro Mass — DATE OF BURIAL: 7/26 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1211 St Paul

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47916

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2521 Jones ST. 25-12 WARD)

2—FULL NAME Theresa E List

(a) RESIDENCE NO. 2521 Jones ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A List

6 DATE OF BIRTH (month, day, and year) Aug 6. 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Elizabeth Suthert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John A List
(Address) 2521 Jones St

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

UL 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to July 24, 1929, that I last saw her alive on July 24, 1929 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm A Fraser, M. D.

7/25. 1929 (Address) 1901 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	7/27 1929
20 UNDERTAKER Wm E Cook	ADDRESS 1317 E Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47917

CERTIFICATE OF DEATH

~~E 47917~~ 202

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital St., Ward)

2-FULL NAME John Williams

(a) RESIDENCE NO. 1120 Beward St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER William Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Berns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Hattie Boyd
(Address) 1120 Beward St

15 7-26 1929 C. HAMPSON JONES, M. D. Registrar

Filed

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Spine
Accidental Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pier #9, Locust Point

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Zeller M. D.

7/25 1929 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Victoria Va	7-26 1929
20 UNDERTAKER Brent Easton	ADDRESS 916 Cen Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47918

E 47918

185

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital. St., 4-26 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Jones.(O)

(a) RESIDENCE NO. 121 N.Amity St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced, HUSBAND of Frances Jones.(O)

6 DATE OF BIRTH (month, day, and year) August 18,1894

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	34	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Consolidated Engineering Co.

9 BIRTHPLACE (city or town)
(State or country) North Carolina.

PARENTS

10 NAME OF FATHER Daniel Jones.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Betsy ------(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina.

14 Informant Frances Jones.(O) wife.
(Address) 121 N.Amity St.

15 Filed JUL 26 1929 19 C. HAMPSON JONES, M. D.
(Registrar)
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the pelvis, Internal injuries. Accidental fall from a beam.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Redwood & South Sts. July 23, 1929

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry & Hosp. Diag.

(Signed) Otto F. Emmandt, M. D.

7/25, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Ne. — DATE OF BURIAL 7-26 1929

20 UNDERTAKER Daniel Eaton — ADDRESS 916 East

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47919

9 ~ E 47919

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp. Ward 2 E.

2-FULL NAME Louis Green Jefferson

(a) RESIDENCE NO. 1039 Eutaw St., Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22-1928

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	1	0	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Fred Green

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Emmonia Green

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) N C

14 Informant Emmonia Green
(Address) 1039 Eutaw St

Filed JUL 26 1929, 19__ C. HAMILTON JONES, M. D. Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1929

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Injury (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Injury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Contusion

(duration) _____ yrs. _____ mos. 1 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) G. E. Brady, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-26 1929
20 UNDERTAKER Daniel Easton	ADDRESS 945 Pine

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

B 47920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1924 E 47920

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 91-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Williams, Jr.

(a) RESIDENCE NO. 612 S. Fremont Ave., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2mth yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willie Williams.

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S. C.

PARENTS

10 NAME OF FATHER Daniel Williams.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Priscella Whiteside.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. C.

14 Informant Mrs. Nellie Ray.
(Address) 612 S. Fremont Ave.,

15 Filed JUL 26 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stab wound of back, involving pleural cavity. (Homicide.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Eugene Zellet, M. D.

7/25. 1929 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Gem	7-26-29
UNDERTAKER Daniel Carter	ADDRESS 416 Eager

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47921

CERTIFICATE OF DEATH

101-00 E 47921

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1820 Aliceanna ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wanda Ostrowska

(a) RESIDENCE NO. 1820 Aliceanna ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

..a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 6-1925

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md,

PARENTS

10 NAME OF FATHER Stanislaw Ostrowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Maryanna Olszewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Stanislaus Ostrowski
(Address) 1820 Aliceanna St.

15 Filed ..., 19 ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 23 1929 to July 25 1929

that I last saw h[illegible] alive on July 25 1929

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 3 days

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur Kay Sauer M. D.

(Address) 1726 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	July 27 1929
20 UNDERTAKER	ADDRESS
George A. Weber	706 S Amity St

IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47922

CERTIFICATE OF DEATH.

3/ E 47922

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1300 N. Stricker ST. 15-22 (WARD)

2-FULL NAME Eva Robinson

(a) RESIDENCE NO. 1300 N. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Robinson

6 DATE OF BIRTH (month, day, and year) 4-15-09

7 AGE	Years	Months	Days	If LESS than 1 day, brs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0'0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Abrams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Estella Abrams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md

14 Informant Agnes Wilmer Aunt (Address) 1300 N. Stricker St

15 Filed JUL 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-23-1929

17 I HEREBY CERTIFY, That I attended deceased from 7-9- , 1929, to 7-23, 1929, that I last saw her alive on 7-23- 1929 and that death occurred, on the date stated above, at 2.35 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

History Pulmonary Tuberculosis (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Initial Insufficiency (duration) yrs. 14 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George C. Bryce, M. D.

, 19 (Address) 1516 N. Mad 181

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: July 26 1929

20 UNDERTAKER: Virginia A Brooks — ADDRESS: 1463 N. Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47923

CERTIFICATE OF DEATH

31 E 47923

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) En route to University Hospital (Ward)

2-FULL NAME Pleas Hamilton

(a) RESIDENCE NO. 2001 Brunt St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Hamilton

6 DATE OF BIRTH (month, day, and year) 8-10-1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35	11	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Swift & Co. 040

9 BIRTHPLACE (city or town)
(State or country) Miss

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Jennie Hamilton
Address 2001 Brunt St.

15 Filed JUL 26 1929, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemoptysis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Zell M. D.

7/25, 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	July 27 1929

20 UNDERTAKER	ADDRESS
Virginia A Brooks	463 N Carey

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47924

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 707 L. Monument St., 11-24 (Ward)

2-FULL NAME Robt Hall

(a) RESIDENCE NO. 707 L. Monument St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) July 22, 1929

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John Hall

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Heath

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant John Hall
(Address) 707 L Monument

15 Filed [illegible] HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) ... yrs. 11 mos. 2 ds.

CONTRIBUTORY (Secondary) due to Syphilis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

July 24 (Signed) A. Finch M. D.
(Address) Coroner

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	July 26 29
20 UNDERTAKER Samuel T. Wensley & Bro	ADDRESS [illegible]

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47925

CERTIFICATE OF DEATH

90 E 47925

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Carter

(a) RESIDENCE NO. 2008 Division St. ? ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement finisher

(h) General nature of industry, business, or establishment in which employed (or employer) ? 83

(c) Name of employer ? Hemorrhage into cerebrum

9 BIRTHPLACE (city or town) (State or country) ? Va.

PARENTS

10 NAME OF FATHER ? Charles Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Va.

12 MAIDEN NAME OF MOTHER Mandy ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Va.

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed 2 9 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-29

17 I HEREBY CERTIFY, That I attended deceased from 1-9, 1928, to 7-25, 1929, that I last saw him alive on 7-25, 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Paresis

over 3 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) Arteriosclerosis; Hypertension; Hemorrhage into cerebrum over 3 yrs. mos. ds. (duration)

18 Where was disease contracted if not at place of death? (old) Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) Marvin M McLean, M. D.

7-25, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 27, 19 29
20 UNDERTAKER	ADDRESS
Samuel H Knuslof	58 Bolle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47926 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47926

100-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 11-28

CITY OF BALTIMORE: (No. Balto. City Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Johnson

(a) RESIDENCE NO. 1313 Myrtle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Mary land

PARENTS

10 NAME OF FATHER Leonard Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary land

12 MAIDEN NAME OF MOTHER Henriette Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/29

17 I HEREBY CERTIFY, That I attended deceased from 7/22, 1929, to 7/24, 1929, that I last saw him alive on 7/24, 1929 and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Carbuncle back of neck

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 7/23/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Humphreys, M. D.

7/24, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL July 27 1929

UNDERTAKER — ADDRESS

Samuel C. Brasley Baltimore

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47927

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47927

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1304 St Matthew ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Simpson

(a) RESIDENCE NO. 327 Colvin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Max Simpson

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 59; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Lewis Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Maggie Francis (daughter)

(Address) 1304 St Matthews St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 24 1929

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 23, 1929, that I last saw her alive on July 22, 1929 and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis and Hypertension (duration) unknown yrs. mos. ds.

18 Where did disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. [illegible] M. D.

7/25 1929 (Address) 1424 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem

DATE OF BURIAL: 7-26 1929

20 UNDERTAKER: Byron Wright

ADDRESS: 1218 McElderry St

important. See instructions on back of certificates.

Cor.—10-10-25—A Co.—100 Bks.

E 47928

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47928

90

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Dorsey

(a) RESIDENCE NO. 1633 Division St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 3 mos. 8 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jessie Dorsey.

6 DATE OF BIRTH (month, day and year) Apr 15-1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	3	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Dorsey
11 BIRTHPLACE OF FATHER (city or town) Baltimore Co
(State or country) Md.
12 MAIDEN NAME OF MOTHER Anne Owens.
13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co
(State or country) Md

14 Informant Edna Dorsey
(Address) 1201 Myrtle Ave

15 Filed JUL 26 1929 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 23rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart 1 D

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Regular

(Signed) H. Hollinshead M. D.
July 24th (Address) Lakeside

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 7-26 1929

20 UNDERTAKER David Fortain — ADDRESS 916 Lex

I. D. [illegible]

I. Be sure that every item is correctly stated. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47929 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 47929

57

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4401 ST. Bridgecroft Road WARD) 57-47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Tilman

(a) RESIDENCE NO. 4401 ST. Bridgecroft Road WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 2 mos. 16 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Philip Tilman

6 DATE OF BIRTH (month, day, and year) May 10 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Mrs St Bowen

(Address) 4401 Bridgecroft Road

15 Filed JUL 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to July 25, 1929, that I last saw h.. alive on July 25, 1929 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr. M. D.

7/25 1929 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 27 1929

20 UNDERTAKER Henry Lautz

ADDRESS 1203 W Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Blks.

E 47930 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 47930

31

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (C. B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 1214 Jefferson ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Jackson

(a) RESIDENCE NO. 515 Colvin st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. 14 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wesley Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

Filed JUL 26 1929 C. HAMPSON JONES, M. D.

Per H Abbott

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 25, 1929, that I last saw her alive on July 25, 1929, and that death occurred, on the date stated above, at 2.05 a. m.

The CAUSE OF DEATH* was as follows:

Caseous pneumonia

(duration) Unknown yrs. moe. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Jas Edward[illegible] M. D.

7-25, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodbury cemetery	July 28, 29
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47931

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47931

90

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 14-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esidale Taylor

(a) RESIDENCE NO. 221 N. Monroe ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?
(State or country) Canada

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

Filed JUL 26 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1907 to July 23, 1927

that I last saw him alive on July 23, 1929

and that death occurred, on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Fatal

over 22 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Clinic Lab.

(Signed) Marvin M. McLean, M. D.

7-24, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	7/26 1929
20 UNDERTAKER Jos. Gloinson & Bro	ADDRESS 1127 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-28-28—L. F. S.—500 Bks.

E 47932 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 47932

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 E Federal ST., 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Finnan

(a) RESIDENCE NO. 1701 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Finnan

6 DATE OF BIRTH (month, day, and year) 7/20/1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Patrick Finnan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Louise Finnan

(Address) 1701 E. Federal St

15 Filed JUL 26 1929, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-29

17 I HEREBY CERTIFY, That I attended deceased from 7/14/29, 19..., to 7/25, 1929 that I last saw h[illegible] alive on 7/25, 1929 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

7/26 1929 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	7/27 1929
20 UNDERTAKER	ADDRESS
George & Ruth	1735 Harford Ave

DEATH to be filled in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec. E-1-10 Blks.

E 47933

✓ E 47933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 N. Broadway WARD) 8 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Zebelein —

(a) RESIDENCE NO. 1209 N. Broadway WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of the late Geo. J. Zebelein

6 DATE OF BIRTH (month, day, and year) Dec. 15th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or..... min.
	67	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Ann Leggett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Anna M. Cullum

(Address) 1209 N. Broadway

15 Filed JUL 26 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 19 29

17 I HEREBY CERTIFY, That I attended deceased from March 7 19 29 to July 24 19 29.

that I last saw h alive on 19

and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver —

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) W. L. Tilney — M. D.

(Address) 622 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL July 27 19 29

20 UNDERTAKER Lilly & Gillis Inc.

ADDRESS 409 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Blks.

E 47934 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **E 47934**

CERTIFICATE OF DEATH. 112

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 232 S Spring St Ward)

2-FULL NAME Julia Hounsley

(a) RESIDENCE NO. 232 S. Spring st Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: James Hounsley

6 DATE OF BIRTH (month, day, and year): 1885 — Inquiry

7 AGE — Years: 44 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 0

PARENTS

9 BIRTHPLACE (City or town): Md.

(State or country)

10 NAME OF FATHER: John H. Beard

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Galloway

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: James Hounsley

(Address) 232 S. Spring st

Filed JUL 26 1929 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1929

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertension

Chr. Gastritis (Duration) yrs. mos. 7 ds.

Contributory (Secondary) Exhaustion (Duration) mos. 1 ds.

July 25 29 Signed G. C. Yates M. D.

19 (Coroner) (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bd. Calvary — Date of Burial July 26 29

20 UNDERTAKER: Mrs R. A. Elliott — ADDRESS 1245 Ashland Ave

(1) Please write plainly in ink. (2) Fill in all blanks. (3) Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47935 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47935

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 420 Druid Hill Ave) (STREET OR AVE.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernard Scott

(a) RESIDENCE NO. 420 Druid Hill Ave STREET WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Scott

6 DATE OF BIRTH (month, day, and year) [illegible] 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Steel Interests

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Isaac Scott

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Bruce

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mary Scott

(Address) 420 Druid Hill Ave.

Filed JUL 26 1929 C. HAMPSON JONES, Registrar

Rec'd [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 - 29

17 I HEREBY CERTIFY, That I attended deceased from July 1 - 1929, to July 25 1929, that I last saw him alive on July 24 - 29 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Aneurism of arch of aorta

(duration) Not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Genetic

(duration) Not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? X ray + Phys. exam.

(Signed) Chas. J. Kellam, M. D.

July 25 1929 (Address) 222 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 29 1929
UNDERTAKER Wm. P. G. Elliott	ADDRESS 1315 Ashland Ave

OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificates.

E 47936

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47936

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH

REGISTERED NO. 23-22

CITY OF BALTIMORE: (No. 1730 Clarkson St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John C. Peters

(a) RESIDENCE NO. 1730 Clarkson St. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 10 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Peters

6 DATE OF BIRTH (month, day, and year) Sept 12 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Casper Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Bradley

(Address) 1730 Clarkson St

15 FILED JUL 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-29

17 I HEREBY CERTIFY, That I attended deceased from May 1 1929 to July 25 1929

that I last saw h alive on July 24 1929

and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 3 mos. 25 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 7/27 1929

20 UNDERTAKER J. Few McCully

ADDRESS 1306 Font

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 lbs.

E 47937

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47937

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 Belgian Ave ST. 27-47 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine M. Burlage

(a) RESIDENCE NO. 831 Belgian Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. \ mos. \ ds. How long in U. S., if foreign birth? 57 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced
~~HUSBAND of~~ the late
(or) WIFE of John J. Burlage

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Lannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Geo. J. Burlage

(Address) 831 Belgian Ave

15 Filed JUL 26 1929 C. HAMPSON JONES, M.D., U[illegible]ERTAKER

(Address) [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1928 to July 25 1929

that I last saw h[illegible] alive on July 25 1929

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(duration) yrs. 9 mos. 25 ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X ray

(Signed) Alan B Freeman M. D.

7/27 1929 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 29 1929
UNDERTAKER Henry Stoeckl Sons Inc.	ADDRESS 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Wellemin

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 ✓

CERTIFICATE OF DEATH

E 47938

1—PLACE OF DEATH St Joseph Hospital

REGISTERED NO. E 47938

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caroline & Orleans ST., 8-16 WARD)

2—FULL NAME Baby boy Wellemin

(a) RESIDENCE NO. 2138 E Orleans ST., 8 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26, 1929

7 AGE: Years | Months | Days | If LESS than 1 day ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Wellemin

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Herman

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Jacob Wellemin

(Address) 2138 E Orleans St

15 Filed JUL 26 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26-1929

17 I HEREBY CERTIFY, That I attended deceased from 7-26-29, 19 ___, to 7-26-29, 19 ___, that I last saw h[illegible] alive on 7-26-29, 19 ___ and that death occurred, on the date stated above, at 2 30 p m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

1 hour

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis 12 hrs

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ___

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Course

(Signed) A B Kennedy, M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 7/26/1929

20 UNDERTAKER: David Leadenwater

ADDRESS: 1525 Lombard St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47939

CERTIFICATE OF DEATH

129 ✓

E 47939

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3925 Fraley ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret J. Ferry

(a) RESIDENCE NO. 3925 Fraley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 11 mos. 11 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of C D Ferry

6 DATE OF BIRTH (month, day, and year) Aug 15 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jared D Kidd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jane Akehurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Jennie Akehurst

(Address) 3925 Fraley St

15 Filed JUL 26 1929 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 29

17 I HEREBY CERTIFY, That I attended deceased from almost constantly for about 15 years, 19, that I last saw her alive on July 25, 1929 and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Uremia - nephritis

(chronic parenchymatous)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. R. Wright, M. D.

July 26 1929 (Address) 1014 S. Elwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 27 1929

20 UNDERTAKER — ADDRESS

John B Spence 1325 N Caroline St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47940

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 L

E 47940

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Sheffield

(a) RESIDENCE NO. 4181 S. Eden ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Sheffield Unknown

6 DATE OF BIRTH (month, day, and year) July 9, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	-	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Sheffield

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Hess

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Record.
(Address)

15 Filed JUL 29 1929 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24/29

17 I HEREBY CERTIFY, That I attended deceased from 7/19, 1929 to 7/24, 1929 that I last saw h alive on 7/24, 1929 and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Pylorus with metastasis to liver

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Consolidation & bronchitis - Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Ed. Lumpkin M. D.

7/29, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 27 19 29
20 UNDERTAKER H B Cook	ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 47941

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1511 Park Ave ST. 14-20 (WARD)

2—FULL NAME Mrs Coralie Howard Haman

(a) RESIDENCE NO. 1511 Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 142 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 3 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: B Howard Haman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co Md

12 MAIDEN NAME OF MOTHER: Louise Cowpile

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co Md

14 Informant: Thos W. Wilson

(Address) 215 Tunbridge Road

15 Filed JUL 26 1929 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 3 1925 to July 25 1929, that I last saw h[illegible] alive on July 25 1929 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis -

(duration) yrs. 11 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - laboratory

(Signed) Kent Clarence M. D.

(Address) 327 Park Av. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakeside Cem Dover Delaware	July 27 1929
20 UNDERTAKER: Harry H. Jenkins Sons	ADDRESS: McElfish & Richards

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47942
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. S. 4-30 WARD)

2—FULL NAME John Ashton

(a) RESIDENCE NO. 101 Dundalk Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	55 single

a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Dec 10 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Auto parts.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John M Ashton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emily H Frampton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs John M Abbott

(Address) 101 Dundalk Ave

15 Filed JUL 26 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 21st, 1929, to July 24th, 1929, that I last saw him alive on July 24th, 1929, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure - Congestion
Enlargement of heart

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 dy

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Lewis C. Gundry, M. D.

July 24th 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL July 27 1929

20 UNDERTAKER John [illegible] — ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47943

CERTIFICATE OF DEATH

31

E 47943

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabelle Burton

(a) RESIDENCE NO. 1290 Battery Ave ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. ... mos. ... ds. How long in U. S., If foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of G. Burton for 21 - 1892 Jr.

6 DATE OF BIRTH (month, day, and year) Feb 22 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
Ga. 39	39	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Arthur Burton
(Address) 1290 Battery

15 Filed ... 19 ... C. HARRISON JONES, M. D. Registrar

JUL 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1929 to July 26, 1929 that I last saw h[e] alive on July 26, 1929 and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No What test confirmed diagnosis? Clinical & Lab

(Signed) Jas. Burns, Jr. M. D.

, 19 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. R. Cemetery	7/29 1929
20 UNDERTAKER	ADDRESS
J. F. Lahey & Sons	318 E. [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47944

CERTIFICATE OF DEATH

49 ✓ **E 47944**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 Gen Hosp. ST. 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Henson.

(a) RESIDENCE NO. 3613 Spaulding Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — — 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work St. Engineer. 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sykesville Md.

PARENTS

10 NAME OF FATHER George Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Anna Culley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Hosp. Record.

(Address)

Filed JUL 27 1929, 19 C. HAMPSON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26-29.

17 I HEREBY CERTIFY, That I attended deceased from 7-17, 1929, to 7-26, 1929.

that I last saw him alive on 7-26 —, 1929.

and that death occurred, on the date stated above, at 10⁰⁵ A. m.

The CAUSE OF DEATH* was as follows:

6a. Head of Pancreas.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dobemia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bl. Pump.

(Signed) [illegible] M. D.

7-29 (Address) Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	7/29 19
20 UNDERTAKER [illegible]	ADDRESS 1311 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47945

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 47945

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 322 S. Mount St. ST. 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Miller

(a) RESIDENCE NO. 322 S. Mount St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Keil

(Address) 322 S. Mount St.

15 Filed JUL 27 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 29

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 24, 1929.

that I last saw h alive on July 24, 1929

and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical signs

(Signed) Jas. T. Hooper, M. D.

7-25, 1929 (Address) 812 W. Fayette

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: July 27/29

UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 W. Lombard St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47946 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47946

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hosps REGISTERED NO. 90

CITY OF BALTIMORE: (No. Balto Md ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lehecka

(a) RESIDENCE NO. 2211 Ashland Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anton Lehecka

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...37...

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hosps (Address) Balto Md

15 Filed JUL 27 1929 C. HAMPSON JONES, Registrar Per H Bell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26-29

17 I HEREBY CERTIFY, That I attended deceased from 12-2-, 19 28, to 7-26, 19 29

that I last saw h she alive on 7-26, 19 29

and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Pneumonia

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Agitated Depression

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Abby Fleetwood M. D.

19 29 (Address) 1016 Penn City Hosps

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 29 19 29
20 UNDERTAKER	ADDRESS
Frost Grace & Son	906 Ward

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47947

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47947

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals (C.B.) REGISTERED NO. 25-T

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Kuchas

(a) RESIDENCE NO. 1625 Church st., Curtis Bay ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Kuchas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Christiana Kucha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address) .....

15 Filed JUL 27 1929 C. HAMPSON JONES, Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to July 25, 1929

that I last saw him alive on July 25, 1929

and that death occurred, on the date stated above, at 2.05 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? clinical and autopsy

(Signed) Jas Elmer [illegible] M. D.

7-25 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. D. Holy Cross	July 19 1929
20 UNDERTAKER Frank Kratofsky	ADDRESS 1911 Wash

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 E 47948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 13-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Riley

(a) RESIDENCE NO. 2942 Kennick Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 51 yrs. 6 mos. 29 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 29/1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn - Railroad

9 BIRTHPLACE (city or town) (State or country) Harpers Ferry W. Va.

PARENTS

10 NAME OF FATHER George Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Loudon Co Va

12 MAIDEN NAME OF MOTHER Sarah Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Loudon Co Va.

14 Informant (Address) Mrs Sarah J. Sullivan (mother) 29 St Edgarad

15 Filed JUL 27 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-26/1929

17 I HEREBY CERTIFY, That I attended deceased from 7-16, 1929, to 7-26, 1929, that I last saw h in alive on 7-26, 1929, and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic alcoholism complicated by Delirium Tremens.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Arthur Ruttenni M. D.

7/26 1929 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: July 29/1929

20 UNDERTAKER: Stuart Memorials — ADDRESS: Balto.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied.

Cor.—12-9-25—A Co.—200 Bks.

E 47949

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 E 47949

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2912 Evergreen Ave. 3-59 Ward)

2-FULL NAME Hettie A. Hamilton Stewart

(a) RESIDENCE NO. 2912 Evergreen Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3/29

7 AGE — Years: — Months: 1 — Days: 23 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Harry T. Stewart

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Dina Schaumloffel

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Harry T. Stewart

(Address) 2912 Evergreen Ave

C. HAMPSON JONES, M. D.

JUL 27 1929 By: EKG Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull accident — (duration) hrs. mins.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Jos. Sinclair Gladden (Coroner) M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem. Date of Burial: July 29 1929

20 UNDERTAKER: Philip Herwig ADDRESS: Arlington

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spog—9-29-28—L. F. S.—500 Bks.

E 47950

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47950

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 46

CITY OF BALTIMORE: (No. 608 Dukeland Ave. ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha L. Carhart

(a) RESIDENCE NO. 608 Dukeland Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank B. Carhart

6 DATE OF BIRTH (month, day, and year) August 31, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Turner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mellisa Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mr. Frank B. Carhart
(Address) 608 Dukeland Ave.

15 Filed C. HAMPSON JONES, M. Registrar

JUL 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1927, to July 25, 1929, that I last saw her alive on July 25, 1929 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows: uterus

Carcinoma of womb with metastasis to liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Clinical

(Signed) W. P. Boyer M. D.

7/27, 1929 (Address) 3048 E. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	July 29 1929
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47951 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47951

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH

REGISTERED NO. 20-69

CITY OF BALTIMORE: (No. 2618 Lehman St. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Knauf

(a) RESIDENCE NO. 2618 Lehman St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Knauf

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Perry Hall Maryland

PARENTS

10 NAME OF FATHER Mr. Doll

11 BIRTHPLACE OF FATHER (city or town) (State or country) United States

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) United States

14 Informant Mrs. C. Stricker

(Address) 2618 Lehman St.

15 Filed JUL 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from 5 July, 1929, to 26 July, 1929

that I last saw her alive on 26 July, 1929

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Z Vance Hooper, M. D.

, 19 (Address) 2565 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michaels Evang. Lutheran Church	July 29 19 29
20 UNDERTAKER Joseph B Cook	ADDRESS 1056 West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 E 47952

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1216 Bank ST., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Salvatore Matarazzo

(a) RESIDENCE NO. 1216 Bank ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	s

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: s

6 DATE OF BIRTH (month, day, and year): Feb 3-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: s

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

PARENTS

10 NAME OF FATHER: Joseph Matarazzo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Eggito

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Joseph Matarazzo

Address: 1216 Bank St

JUL 27 1929

Filed ....., 19 C. HAMPSON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25-1929

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to July 25, 1929, that I last saw h[illegible] alive on July 25, 1929, and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Catarrh

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi DeStefano M. D.

July 26, 1929 (Address) 1407 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 27 1929

20 UNDERTAKER: M. W. E. Dashiell Inc

ADDRESS: 371 Cathedral

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Blks.

WURTZBACHER

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47953

E 47953

CERTIFICATE OF DEATH

129

21-29

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 612 Ridgely St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wurtzbacher

(a) RESIDENCE NO. 612 Ridgely St. 21 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Margaretha Wurtzbacher

6 DATE OF BIRTH (month, day, and year) March 13, 1852

7 AGE: Years 77 Months 4 Days 12

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Otto Wurtzbacher

(Address) 612 Ridgely St

JUL 27 1929

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 - 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to July 25, 1929.

that I last saw h— alive on July 24, 1929.

and that death occurred, on the date stated above, at 5:25 p. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [illegible], M. D.

7/26/29 19 (Address) 51 Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem.; Date of Burial July 29, 1929

20 UNDERTAKER C. H. Dill; ADDRESS 3109 Frank Ave

S.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47954

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47954

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Mercy Hospital ST. 1107 WARD)

REGISTERED NO. 74-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fred Nelson

(a) RESIDENCE NO. 605 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Alfred Nelson

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE: Years 52 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10 NAME OF FATHER Mr Nelson Deceased

11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Hospital Records

(Address)

Filed JUL 27 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/29

17 I HEREBY CERTIFY, That I attended deceased from 7/19, 1929 to 7/26, 1929

that I last saw h Living alive on 7/26, 1929

and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:

(a) Cerebral thrombosis

(duration) yrs. mos. 7 ds. 14

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. ? mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm D McFaul Jr, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys, Hampden	July 27, 29
20 UNDERTAKER	ADDRESS
C. Leroy Stiffler, Inc.	125 E. North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 47955

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47955

CERTIFICATE OF DEATH.

1929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 16-29 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Allen

(a) RESIDENCE NO. 1019 Booth ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Martha Allen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant wife

(Address)

Filed JUL 27 1929

Wm. JAMESON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/20, 1929, to 7/25, 1929, that I last saw h[illegible] alive on July 25, 1929, and that death occurred, on the date stated above, at 10:5 A m.

The CAUSE OF DEATH* was as follows: Tumor Broad-ligament

CONTRIBUTORY (Secondary) (duration) Chr Nephritis (education) yrs. mos 3 ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. Jackson M. D.

1/25 1929 (Address) Good Samaritan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL July 29 1929

20 UNDERTAKER Mrs Kate R Williams

ADDRESS 322 W. Lexington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47956

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47956

CERTIFICATE OF DEATH

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 704 Sarah Ann St., 4-1 Ward)

2-FULL NAME Hattie Roane

(a) RESIDENCE NO. 704 Sarah Ann St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Such yrs. mos. dx. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary Baynard
(Address) 704 Sarah Ann St

15 Filed JUL 27 1929 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemoptysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

7/27 1929 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	July 28 1929
20 UNDERTAKER Jas Peter A. Holleman	ADDRESS 5 E Preston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47957. HEALTH DEPARTMENT—CITY OF BALTIMORE E 47957.

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N. Glover ST., 9-10 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Eileen Arthur

(a) RESIDENCE NO. 521 N Glover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-1-28

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	1	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Austin H Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Kiesling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Anna Arthur

(Address) 521 N Glover st

15 JUL 27 1929 C. HAMPSON JONES Registrar

Per Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27-29

17 I HEREBY CERTIFY, That I attended deceased from July 22, 19 29, to July 27, 19 29,

that I last saw h 27 alive on July 26, 19 29

and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Groll, M. D.

7/27, 19 29 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cath	July 29 1929
UNDERTAKER	ADDRESS
J H U E Hupp Co	37 Lex

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47958 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 47958

CERTIFICATE OF DEATH

117

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 16-68 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fred Hutchins

(a) RESIDENCE NO. 1709 Hubeland Ave ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Night Supt. Ice Co

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston, Mass

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mrs. Alberta Billmeyer

(Address) 2502 Winchester St.

15 Filed JUL 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 25, 1929, that I last saw him alive on July 25, 1929 and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis, Ruptured appendix

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-21-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Luther E. Leech, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 29 '29
20 UNDERTAKER	ADDRESS
H. W. Renton	2238 W Mont

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47959 HEALTH DEPARTMENT—CITY OF BALTIMORE 35 E 47959

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 814 N. Spring ST. 10-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chas Stewart

(a) RESIDENCE NO. 814 N Spring ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

Life

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widnwed, or Divorced, (write the word)
M	C	Married

a If married, widowed, or divorced HUSBAND of [redacted] Josephine Stewart

6 DATE OF BIRTH (month, day, and year) March 17, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Meter Wks.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jacob Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sedonia Lee.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Josephine Stewart (wife)

(Address) 814 N Spring St.

15 Filed [illegible] 19 [illegible] C. H. JOHNSON JONES, M. D. Registrar

UL 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to July 24, 1929, that I last saw h im alive on July 23, 1929 and that death occurred, nn the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Pyo-Nephrosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Abscess Hip.

(duratinn) yrs. 1 mns. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autnpsy? no

What test confirmed diagnosis? Physical & Labr

(Signed) [redacted] M. D.

, 19 (Address) 1420 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature nf Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cemetery	July 28 1929
UNDERTAKER	ADDRESS
Chas. E. Johnson	46 N Carlton St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47960

CERTIFICATE OF DEATH

90 ✓

E 47960

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Preston Apartment ST., 1219 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Snowden Marshall

(a) RESIDENCE NO. Preston Apartment ST.. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Marshall

6 DATE OF BIRTH (month, day, and year) Nov 13, 1841

7 AGE 87 88	Years	Months 8	Days 14	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ none

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Anne Arundel Co.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Snowden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER Ann R Nicols

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs. Lee Marshall
(Address) 1937 Eutaw Place

15 Filed JUL 27 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27/29.

17 I HEREBY CERTIFY, That I attended deceased from July 12 1929, to July 27 1929.

that I last saw her alive on July 27 1929

and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency, arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis Secondary Anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) H. A. Chatard, M. D.

July 27th 1929 (Address) 1300 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 29 1929
20 UNDERTAKER	ADDRESS
H. W. Jenkins Sons Co	Richard T. McCulloh Jr

JUL 27 1929

IMPORTANT—Information should be carefully supplied. Avoid ambiguity. Each question must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-002

E 47961
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 47961
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 3611 Oakmont Ave. 27-56 (WARD)

2-FULL NAME Infant Rygland.

(a) RESIDENCE. No. 3611 Oakmont Ave. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 - 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. ~~min.~~
	2 hours			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robt. Rygland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Wilhelmina Fischer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wilhelmina Rygland
(Address) 3611 Oakmont Ave

15 Filed JUL 27 1929 C. HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Time of birth to death — 19 ; that I last saw her alive on July 26 1929, and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:
Failure of Ovalbumin to clear & immature organs. (3 months child)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. Beckley, M. D.
19 (Address) 3337 Belvedere Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	JUL 27 1929
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 V

E 47962

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Latrobe ST. 12-19 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Turner

(a) RESIDENCE NO. 1712 Latrobe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Turner

6 DATE OF BIRTH (month, day, and year) Aug 6-69

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Columbus Ga

PARENTS

10 NAME OF FATHER Louis Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Dina Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant James F. Turner

(Address) 1712 Latrobe

JUL 28 1929

HARRY H. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27-29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 19 29, to July 27 19 29, that I last saw h alive on July 26 19 29 and that death occurred, on the date stated above, at 1 20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Sanguine

CONTRIBUTORY (Secondary) Mitral Stenosis (duration) yrs. 6 mos. 10 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. H. Hatcher M. D.

7/28, 19 29 (Address) 1515 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL July 28 1929

20 UNDERTAKER Sam'l H. Howard & Son — ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47963

CERTIFICATE OF DEATH.

162
E 47963

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U. B. G. Hospital (St.) 14-54 (Ward)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Blum.

(a) RESIDENCE NO. West Balto Gen Hosp. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 hrs 11 min ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): July 27 1929.

7 AGE — Years — Months — Days: If LESS than 1 day hrs. or min. 2 hrs 11 min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Rose Resnick.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Samuel Blum

(Address) 2209 Reisterstown Rd

L 28 1929 C. HARRISON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27. 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to July 27, 1929.

that I last saw h[illegible] alive on July 27, 1929.

and that death occurred, on the date stated above, at 8 30A. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia Livida

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? none.

(Signed) J. B Alessi, M. D.

, 19 (Address) West Balto Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herrington — DATE OF BURIAL: July 28 1929

20 UNDERTAKER: A Lennon Bro — ADDRESS: Balto Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47964 — 129 — E 47964

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 S. Curley. St. ST 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Kuczborski

(a) RESIDENCE NO. 610 S. Curley St. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pelagia Kuczborski

6 DATE OF BIRTH (month, day, and year) Dec 26-186[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Kuczborski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Zajdzonka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14

Informant Pelagia Kuczborski

(Address) 610 S, Curley St,

15

Filed JUL 28 1929, 19

C. HAMILTON JONES, M. D. Registrar

Per KLK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25. 1929

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1929 to July 25, 1929.

that I last saw h[illegible] alive on July 25, 1929

and that death occurred, on the date stated above, at 7.15 P.M.

The CAUSE OF DEATH* was as follows:

Embolism of Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Bruno Kuczborski, M. D.

July 26, 1929 (Address) 725 S Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary July 29.

DATE OF BURIAL: 1929 19

20 UNDERTAKER: F. X. Ozazewski

ADDRESS: 725 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47965

CERTIFICATE OF DEATH

74-001

REGISTERED NO. E 47965

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2803 W. Lafayette Ave 6-68 ST.) (WARD)

2—FULL NAME John J. Bloecher

(a) RESIDENCE NO. 2803 W. Lafayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pauline Bloecher

6 DATE OF BIRTH (month, day, and year): Jan 18, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Butcher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Philip Bloecher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva Meis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Pauline Bloecher

(Address) 2803 W. Lafayette Ave

15 Filed JUL 28 1929 HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1928 to July 26, 1929

that I last saw h alive on July 26, 1929

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Geo A Straus, M. D.

7/27, 1929 (Address) 1805 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	July 29, 1929

20 UNDERTAKER: Wm & Mus. J. W. Teufel & Son

ADDRESS: 801 W Fay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47966 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 47966

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5130 Belair Rd ST., 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James M. Moore

(a) RESIDENCE: (No. 5130 Belair Road ST., WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Anna V. Moore

6 DATE OF BIRTH (month, day, and year) May 20 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Kingville Md

PARENTS

10 NAME OF FATHER Alexander Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kingville Md.

12 MAIDEN NAME OF MOTHER Mary Mc Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Anna V. Moore
(Address) 5130 Belair Road

15 Filed JUL 28 1929 C. H. Perry Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 29

17 I HEREBY CERTIFY, That I attended deceased from Apr 2, 1929, to July 26, 1929.

that I last saw h[illegible] alive on July 25, 19 29

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Carcoma of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W Walsh M. D.

7/27. 1929 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. John, Kingsville Md	July 29 1929

20 UNDERTAKER ADDRESS

William G. Schaefer 186 Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47967

CERTIFICATE OF DEATH

90 ✓ E 47967

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 810 Union Ave (St.) 23-52 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth A. Erney.

(a) RESIDENCE NO. 810. Union ave ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Erney

6 DATE OF BIRTH (month, day, and year): May 30 1857

7 AGE — Years: 72 — Months: 1 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Amelia A. Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Jessie Jenkins

(Address) 2903 Edmondson ave

15 Filed JUL 26 1929, 19 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 19 29, to July 26th, 19 29, that I last saw her alive on July 26th, 19 29, and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Hemorrhage by Aneurism Dissecting

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): myocarditis. senility.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) H. A. Fennell, M. D.

July 29 19 29 (Address) 3615 - Fair. Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery	July 29 1929
20 UNDERTAKER	ADDRESS
E. Walter Davis	3307 Fairmount Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Frances Wichert

47968

G47968

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 47968

3-4

REGISTERED NO. 47968

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 S. Bond St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Wichert

(a) RESIDENCE NO. 728 S. Bond St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 027

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Wichert

(Address) 728 S. Bond St.

15 Date JUL 28 1929, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1928 to July 26, 1929

that I last saw h[illegible] alive on July 26, 1929

and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ✓

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab

(Signed) Gilbert L. Levy, M. D.

July, 1929 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn July	31 19 29
20 UNDERTAKER	ADDRESS
Grimm & Wade	701 E Chase

IMPORTANT—Information should be carefully supplied. Write plainly. Answer all questions. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

47969 E 47969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 47969 47969 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2913 Dillon St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Ida Schraeders

(a) Residence No.... 2913 Dillon St., Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Suburban yrs. mos. ds. How long in U. S., if of foreign birth? 87 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of widow

6-DATE OF BIRTH (month, day and year) 1842

7-AGE. 87 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Poland
(State or Country),

PARENTS.

10-NAME OF FATHER, Jakubowski

11-BIRTHPLACE OF FATHER (city or town)... Poland
(State or Country),

12-MAIDEN NAME OF MOTHER, dont know

13-BIRTHPLACE OF MOTHER (city or town)... Poland
(State or Country),

14- (Informant) Josephine Kowalewska

(Address) 2913 Dillon St.

15- JUL 28 1929 C. HAMPSON JONES, M. D. Registrar.

Per CRK

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 25, 1929

17- I HEREBY CERTIFY, That I attended deceased from July 18 19 29 to July 25 19 29

that I last saw her alive on July 23, 19 29

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. F. Bronushas, M. D.

7-27-, 19 29 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus Cem. DATE OF BURIAL. July 29 19 29

20-UNDERTAKER. Stephen J. Fralkowski ADDRESS 1000 S. Kenwood

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47970

1-PLACE OF DEATH

City of Baltimore: (No. 1625 N. Fulton Ave. 15-21 Ward)

2-FULL NAME John M. Turnbaugh

(a) RESIDENCE NO. 1625 N. Fulton Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

E 47970

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) July 21 1929

7 AGE Years | Months | Days 7 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm F. Turnbaugh

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Dora Wilkinson

13 BIRTHPLACE OF MOTHER (City or town) Baltimore Co.
(State or country) Md.

14 Informant Wm F. Turnbaugh
(Address) 1625 N. Fulton Ave.

15 Filed JUL 28 1929 C. HAMPSON JONES, M. D. Registrar
By Clk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 28th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Diphtheria

CONTRIBUTORY (Secondary) Malnutrition (duration) yrs. mos.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home
Did operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Negative

(Signed) Harold Kirk M. D.
July 28 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL July 29 1929

20 UNDERTAKER Asphalt Lime Co. — ADDRESS W Bd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4792 E 47971 — 117 — E 47971 — 47971

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Mt. Sinai Hosp. ST. 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Kasten.

(a) RESIDENCE NO. 2914 Kate Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Husband Mrs. Charles Kasten

6 DATE OF BIRTH (month, day, and year) March 9 1870

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Retail

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Kasten

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Catherine Zink

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Hospital Records (Address)

15 Filed JUL 28 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-29

17 I HEREBY CERTIFY, That I attended deceased from 7-25-29, 19 ..., to 7-27-29, 19 ..., that I last saw h alive on 7-27-29, 19 ..., and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic diseases Heart

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-26-29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Jno A Donaghues M. D.

19 (Address) 111 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	July 29, 29

20 UNDERTAKER John O Mitchell and Son ADDRESS 1900 Eutaw Place

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

227229 E 47972 — 4797 E 47972 — E 47972 — x 32 — 47972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene G. Stuart

(a) RESIDENCE NO. Louisville, Kentucky ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Marybelle Stuart

6 DATE OF BIRTH (month, day, and year) 1/13/89

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work State Agent 86

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Insur Co

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Robt E. Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Annie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 28 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28-1929

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to July 28, 1929, that I last saw him alive on July 28, 1929 and that death occurred, on the date stated above, at 350 A m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis; pulmonary tbc, bilateral; tbc of prostate; tuberculous enteritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Meningitis for 20 days.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Louisville, Ky.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray.

(Signed) Benj. G. Greenburg, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louisville Ky.	July 28 1929

20 UNDERTAKER John O Mitchell & Son ADDRESS 1900 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47973

CERTIFICATE OF DEATH.

E 47973

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry D Strow

(a) RESIDENCE NO. Bronxboro Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Samuel —

11 BIRTHPLACE OF FATHER (city or town) Washington Co. Md

(State or country)

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant J. H. Hospital

(Address)

15 Filed JUL 28 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging while Suffering from Mental Distress

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

July 4 (Signed) W. J. Reis M. D.

(Coroner)

, 19 29 (Address) 1639 Bucknell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) Jan. 19. 29 to July 28. 29

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Bronxboro Md

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rosehill Cemetery July 30 1929 Date of Burial

20 UNDERTAKER William J Bost & Son Bronxboro ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47974

CERTIFICATE OF DEATH

90 E 47974

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 327 Whitridge Ave., ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Hennelly

(a) RESIDENCE NO. 327 Whitridge Ave., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~WIFE~~ Margaret Hennelly

6 DATE OF BIRTH (month, day, and year) April 14-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER John Hennelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winfred Tafe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant ~~X~~Mrs Margaret Hennelly

(Address) 327 Whitridge Ave.,

15 Filed JUL 28 1929, 19.. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th 1929

17 I HEREBY CERTIFY, That I attended deceased from 2/23/29, 19.29, to July 26, 1929.

that I last saw him alive on July 26 1929

and that death occurred, on the date stated above, at 2-20 P. m.

The CAUSE OF DEATH* was as follows: Myocardial Failure

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) D. O. Franklin, M. D.

7/27, 19 29 (Address) 9 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery.	7/29/29

20 UNDERTAKER J. J. Jackson Sons

ADDRESS W. Pa

IMPORTANT—Should be carefully supplied. Avoid abbreviations. Write OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47975

CERTIFICATE OF DEATH

89

E 47975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Fire Department Headquarters Gay & Lexington Sts. St. 15-61 Ward)

2-FULL NAME Charles Christian Prince.

(a) RESIDENCE NO. 3708 Forest Park Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) June 7, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Telegraph Operator.
(b) General nature of industry, business, or establishment in which employed (or employer) Fire Department.
(c) Name of employer City of Baltimore.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Conrad Prince.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Carolyn Smith.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Blanche Prince. (sister)
(Address) 3708 Forest Park Ave.

Filed JUL 28 1929. S. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto Heinrandt, M. D.

7/26, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 29 1929
20 UNDERTAKER	ADDRESS
J. J. Tucker & Sons	[illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH E 47976 REGISTERED NO. B 47976

CITY OF BALTIMORE: (No. 3641 Parkheights Ave ST. 55-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Bugen

(a) RESIDENCE NO. Edeston Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 6 mos. ds. How long in U. S., if foreign birth 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Rose Bugen

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Benj Bugen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mutkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Herman Good

(Address) 3641 Parkheights Ave

Filed JUL 29 1929 RAMSAY JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29/29

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to July 29, 1929.

that I last saw him alive on July 28, 1929.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis and myocarditis.

— (duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Urinary & general physical

(Signed) Nathan H Shapiro M.D. M. D.

. 19 (Address) 2319 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Pa	July 31 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

INSTRUCTIONS: Certificate should be carefully supplied. Avoid abbreviations. Write plainly in ink. Cause of death must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47977

CERTIFICATE OF DEATH

E 47977.

1—PLACE OF DEATH

REGISTERED NO. 63744

CITY OF BALTIMORE; (No. University Hosp, ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillie Marsh

(a) RESIDENCE NO. Tylerton Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Calvin Marsh

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	thirty yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer

9 BIRTHPLACE (city or town) Tylerton

(State or country) Somerset Co. Md.

PARENTS

10 NAME OF FATHER Alex Bradshaw

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Marshall dies

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant University Hosp Records

(Address)

15 Filed JUL 29 1929, 19 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28-1929

17

I HEREBY CERTIFY, That I attended deceased from July 5 , 1929, to July 28 , 1929.

That I last saw h er alive on July 28 , 1929

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) 4 yrs. ? mos. ds.

Entire left lung (duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of July 11-1929

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) Lewis P. Gundry, M. D.

7-28, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tylerton Md	7-29 1929
20 UNDERTAKER	ADDRESS
John A. Bradshaw	Crisfield Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47978

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 729 S. Ellwood Ave (St.) (WARD)

2—FULL NAME Rose C. Dunphy

(a) RESIDENCE NO. 729 S. Ellwood Ave (St.)

(Usual place of abode) WARD

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard A. Dunphy

6 DATE OF BIRTH (month, day, and year): Jan 29 - 1863

7 AGE: Years 66 Months 5 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt

PARENTS

10 NAME OF FATHER: James Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ire.

12 MAIDEN NAME OF MOTHER: Rose O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ire.

14 Informant: Miss Dunphy

(Address) 729 S. Ellwood Ave

15 Filed JUL 29 1929. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25, 29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1926, to July 25, 1929.

That I last saw her alive on July 25, 1929.

And that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Transverse Colon

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) T. Joseph Tenney, M. D.

(Address) 608 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 7/29/1929

20 UNDERTAKER: J. J. Moran

ADDRESS 3000 E. Balto

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47979 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ~~E 47979~~

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 Pontiac ave ST. 25-75 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mabel C. Potee

(a) RESIDENCE NO. 100 Pontiac ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. L. Potee

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) Pearlejo Lunch Room

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ennto, Md.

PARENTS

10 NAME OF FATHER Julian Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Hester Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Julian Bryant

(Address) 100 Pontiac ave.

15 Filed JUL 29 1929, 19

THAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27/29

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to July 27, 1929

that I last saw h alive on July 27, 1929

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. C. H. Cornbrooks M. D.

July 28, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL July 29 1929

20 UNDERTAKER Margaret L. Flynn ADDRESS 1422 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47980

CERTIFICATE OF DEATH

161 1001

E 47980

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 S. Bond ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bronislawa Michalski

(a) RESIDENCE NO 624 S Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22. 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanley Michalski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Kaikowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Stanley Michalski

(Address) 624 S Bond St

15 Filed JUL 29 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-29

17 I HEREBY CERTIFY, That I attended deceased from 7-22-29 to 7-28 1929

that I last saw h alive on 7-28 1929

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Shock following Operation for Strangulated Hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? undetermined

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Surgical

(Signed) J. Ted Ross M. D.

1929 (Address) 606 Mercantile Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	7/29 1929
20 UNDERTAKER	ADDRESS
F. A. Czapanski	1330 Eastern Ave.

mation should be carefully supplied. Age should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 47981

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 3303 McElderry St., (Ward) 11

2-FULL NAME Infant Bouhoff

(a) RESIDENCE NO. 3303 McElderry St., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27. 29

7 AGE — Years — Months — Days — If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Bouhoff

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Madelin Heyse

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Henry Bouhoff
(Address) 3303 McElderry St

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D.
By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1929

17 I HEREBY CERTIFY, That I attended deceased from July 27 1929 to July 28 1929
that I last saw h alive on July 28 1929
and that death occurred, on the date stated above, at 3a m.
The CAUSE OF DEATH* was as follows:

Prematur Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed William J. Rydzewski M. D.
(Address) 3179 80, & Lakewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 29 1929

20 UNDERTAKER: George L. Schwab — ADDRESS: 1501 Eutaw Ave

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47982

CERTIFICATE OF DEATH.

129 E 47982

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 147 N. Ellwood Ave ST.) 6-11 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ulysses G. Hampton Sr.

(a) RESIDENCE. NO. 147 N. Ellwood Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Thompson

6 DATE OF BIRTH (month, day, and year) Jan. 20th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Robert Hampton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. D. Hampton (Address) 147 N. Ellwood Ave.

15 Received JUL 29 1929 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26/1929

17 I HEREBY CERTIFY, That I attended deceased from 5/23/29, 19 . to 7/26/29, 19 29. that I last saw him alive on 7/25/29, 19 29. and that death occurred, on the date stated above, at 1:20 a. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy Prostate (Chronic) (Supra-pubic prostatectomy).

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic nephritis - Toxaemia - (duration) yrs. 1 mos. 28 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/29/29.

Was there an autopsy? No

What test confirmed diagnosis? Pathologists report.

(Signed) George A Bowden, M. D.

7/27 1929 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon, Md.	7/29/1929

20 UNDERTAKER C. D. Fanning Home - 1938 E. Lafayette Ave. ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47983

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47983

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 17-24 Ward)

REGISTERED NO. 188-002

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Frances

(a) RESIDENCE NO. 524 W. Hoffman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Frances

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Benj. Walker

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mr Herbert Frances
(Address) 524 W. Hoffman St

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereof and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull. Struck by St. Car. Accidental Death (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Franklin & Pearl Sts

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

7/29 1929 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	July 29 '29
20 UNDERTAKER Samuel Kemsley	ADDRESS 1728 Bolton

I. N. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

47984

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47984

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 510 N. Fremont Ave ST. 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie C Brown

(a) RESIDENCE NO. 510 N. Fremont Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H Brown

6 DATE OF BIRTH (month, day, and year) July 5th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Conrad Schutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Atwinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

--PARENTS

14 Informant Mrs Schutz

(Address) 510 N Fremont Ave

15 Filed JUL 29 1929, 19 H. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28-29

17 I HEREBY CERTIFY, that I attended deceased from January 1, 1929, to July 28, 1929, that I last saw her alive on July 28, 1929, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J Murray, M. D.

7-28, 1929 (Address) 510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U. S National Cem	July 30, 1929
20 UNDERTAKER	ADDRESS
C. Howard Evans	38 E Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 47985

1—PLACE OF DEATH

REGISTERED NO. 26-37

CITY OF BALTIMORE: (No. 515 S. Leheigh ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME R. Emmett Arthur

(a) RESIDENCE NO. 515 S. Leheigh ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret H Arthur

6 DATE OF BIRTH (month, day, and year) July 15. 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Core Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos J Arthur.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret C Donohue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Margaret H Arthur

(Address) 515 S Lehigh St

15 Filed JUL 29 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1929

17 I HEREBY CERTIFY, That I attended deceased from July 18 1929 to July 29 1929.

that I last saw h alive on 19

and that death occurred, on the date stated above, at 12 25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

at State Sanitarium from April

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Amputation

(Signed) R. C. Lamm, M. D.

1929 (Address) 4502 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL July 29 1929

20 UNDERTAKER John Merid

ADDRESS 2008 Orleans

Make statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47986 — REGISTERED NO. E 47986

24-35 182

1-PLACE OF DEATH: Crook Ship Yard.

City of Baltimore: (No.) Foot of Andre St. (Street) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Paul Lenivy.

(a) RESIDENCE NO. 1138 Cooksie St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) June 11, 1917

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	12	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter Lenivy.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Checko Slavakia.

12 MAIDEN NAME OF MOTHER Johanna Hanakovic.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Checko Slavakia.

14 Informant Peter Lenivy. (father)
(Address) 1138 Cooksie St.

15 Filed JUL 29 1929 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a wharf while crabbing.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Reinhardt, M. D.

7/27 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jul. 29 19 29

20 UNDERTAKER: George W. Zinkler — ADDRESS: 1737 E. Eager St

JUL 29 1929

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47987

CERTIFICATE OF DEATH.

E 47987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1825 Covington St. (ST.) 24-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Pearson Sing

(a) RESIDENCE NO. 1833 Covington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 15 mos. — ds. How long in U. S., if of foreign birth? yrs. 15 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Child

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year) Apr. 28. 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	15		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Harry A. Sing.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Marion Md.

12 MAIDEN NAME OF MOTHER Marg. E. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant: Mrs Wm. A. Sings (Address) 1825 Covington St.

15 Filed JUL 29 1929, 19

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 28. 29. 19

17

I HEREBY CERTIFY, That I attended deceased from 4. 17. 29. , 19 , to 7. 28. 29. , 19 ,

that I last saw him alive on 7. 28. 29. , 19 ,

and that death occurred, on the date stated above, at 8⁰⁰ P. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) — yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Heat exhaustion

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical—Microscopic

(Signed) Philip B. Fowler, M. D.

7. 27. 29. (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	7/30 1929
20 UNDERTAKER	ADDRESS
J. Fred McCully	1306 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-12-23—M&T—500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47988

CERTIFICATE OF DEATH.

31

E 47988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Cantrell Ave 5-8 WARD)

2-FULL NAME James Hicks

(a) RESIDENCE No. 628 Cantrell Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE: Years 35 | Months — | Days — | If LESS than 1 day, hrs or mins

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs O Lee Summerlee

(Address) 1708 E Monument St

15 Filed JUL 29 1929 WILLIAM H. LEVERTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1929

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to July 25, 1929, that I last saw h[illegible] alive on July 25, 1929 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

(1) Pulmonary Phthisis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene L Hall, M. D.

7-29, 1929 (Address) 608 Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary — DATE OF BURIAL July 29 1929

20 UNDERTAKER: [illegible] — ADDRESS 2108 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47989

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

E 47989
REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp. 1-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Miller

(a) RESIDENCE No. 942 N Durham ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	[illegible]	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Edward County Va.

PARENTS

10 NAME OF FATHER Richard Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Crawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mother

(Address)

15 Filed JUL 29 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/26 1929

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 26, 1929, that I last saw her alive on July 26, 1929 and that death occurred, on the date stated above, at 12 35 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) about 6 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Blood Culture

(Signed) Geo. McDonald M. D.

19 Address Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon — DATE OF BURIAL July 29 1929

20 UNDERTAKER Mrs. A. C. Elliott — ADDRESS 1725 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47990

40

E 47990

REGISTERED NO. 27-43

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6106 Fairfield Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward D. Geier

(a) RESIDENCE NO. 6106 Fairfield Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Elly C. Geier

6 DATE OF BIRTH (month, day, and year) March 5-1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Car Shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Anthony Geier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Frank Geier

(Address) 6106 Fairfield Ave

15 Filed JUL 29 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 29

17 I HEREBY CERTIFY, That I attended deceased from June 14th 1929 to July 27th 1929,

that I last saw h alive on July 27th 1929.

and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Dilatation

Duration 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystic Kidneys

Duration yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard [illegible] M. D.

7-29 1929 (Address) 211 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine wood Cem	7-30 1929

20 UNDERTAKER Leonard J. Rauch

ADDRESS 2405 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 47991

CERTIFICATE OF DEATH

E 47991

REGISTERED NO.

1—PLACE OF DEATH St Joseph Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Aurelia St. WARD 5

2—FULL NAME Baby boy white

(a) RESIDENCE NO. 6506 Maywood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Married~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1929.

7 AGE	Years	Months	Days	If LESS than 1 day 2 hrs. or min.
1day			1day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James White

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Fetz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant A. Calas M.D.
(Address)

15 Filed JUL 29 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-27-29

17 I HEREBY CERTIFY, That I attended deceased from 7-27-29, 19 to 7-27-29 19,
that I last saw h alive on dead 7-27-29. 19
and that death occurred, on the date stated above, at 4 p. m.
The CAUSE OF DEATH* was as follows:

Still Born

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nil (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of None

Was there an autopsy? Yes

What test confirmed diagnosis? Born dead

(Signed) W B Hundley M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JUL 29 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47992

CERTIFICATE OF DEATH

74-002

E 47992

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 11-15 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr Edmund Barrell

(a) RESIDENCE NO. 10 E Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jas. N. Barroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant H. Irvine Keyser

(Address) Stevenson Md.

15 Filed JUL 29 1929 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1929

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to July 29, 1929, that I last saw h alive on July 29, 1929 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia —

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical —

(Signed) J. Lyke, M. D.

7/29, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Glen	July 30th 1929
20 UNDERTAKER Henry Jenkins Sons Co	ADDRESS Garland Bro. Co. Balto

H.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47993

CERTIFICATE OF DEATH

90 E 47993

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1019 Bush ST. 21-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patrick F. Mulligan

(a) RESIDENCE NO. 1019 Bush ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosa A. Mulligan

6 DATE OF BIRTH (month, day, and year) March 8th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman for

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Tube Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Owen J. Mulligan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Gilroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Rosa A Mulligan

(Address) 1019 Bush St.

15 Filed JUL 29 1929, C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19..., to July 28, 1929

that I last saw him alive on July 27, 1929

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation.

Indefinite
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) H. H. Campbell M. D.

July 29, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	July 31st 1929
20 UNDERTAKER	ADDRESS
Wm. J. Howard & Son	Garrison Blvd

N. B.—WRITE PLAINLY. PHYSICIANS should state CAUSE stated EXACTLY. AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47994

CERTIFICATE OF DEATH.

E 47994

113

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) John Hopkins Hospital (St.) (Ward) 15-b-3

2-FULL NAME Herman Krieger

(a) RESIDENCE NO. 4019 Barrington Road (St.) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14. 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.... none

(b) General nature of industry, business, or establishment in which employed (or employer)....

(c) Name of employer

9 BIRTHPLACE (city or town)....

(State or country) Md

PARENTS

10 NAME OF FATHER Abraham Krieger

11 BIRTHPLACE OF FATHER (city or town)....

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ruth Summerfield

13 BIRTHPLACE OF MOTHER (city or town)....

(State or country) Balto Md

14 Informant A. Krieger

(Address) 4019 Barrington Road

C. HAMPSON JONES, M.D.

Coroner

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29. 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Gastro Intestinal Indigestion

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

7/29/29 (Signed) G C Glader M. D.

(Coroner)

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Washington Rd

Date of Burial 7/29 1929

20 UNDERTAKER [illegible] Sherman Bro

ADDRESS [illegible] Balto Md

JUL 29 1929

Dep

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. 2—500 Blks.

E 47995

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47995

CERTIFICATE OF DEATH

1—PLACE OF DEATH South Balto. Fed Hosp. REGISTERED NO. 2433

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothy Miller

(a) RESIDENCE NO. Margaret Ave, Manor ST., WARD Essex Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of John A Miller

6 DATE OF BIRTH (month, day, and year) May 3, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brandon Butte

PARENTS

10 NAME OF FATHER Charles Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John A. Miller

(Address) Margaret Ave Essex

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/29

17 I HEREBY CERTIFY, That I attended deceased from 7/23, 1929, to 7/28, 1929

that I last saw h[illegible] alive on 7/28, 1929

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonic Tuberculosis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Puerperal Infection

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J W Gilles, M. D.

19 (Address) S. B. Fed Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	7/30 1929
20 UNDERTAKER William Cook	ADDRESS 1217 St Paul

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Russell, 3902 Groveland Ave

E 47996 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 **E 47996**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Egerton Rd ST., 56 63 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Catherine Linthicum

(a) RESIDENCE NO. 3710 Egerton Rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph B. Linthicum

6 DATE OF BIRTH (month, day, and year) May 12. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Brumm

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Edgar L. Linthicum

(Address) 3710 Egerton Rd

15 Filed JUL 2 1929, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25. 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-22, 1929, to 7-28, 1929, that I last saw h[illegible] alive on 7-28, 1929, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Henry Duffield, M. D.

7-29, 1929 (Address) 3902 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: 7/31 1929

20 UNDERTAKER: W. Cook — ADDRESS: 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47997

CERTIFICATE OF DEATH

+ 146

E 47997

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 309 W Stricker ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sula Young.

(a) RESIDENCE NO. 309 W. Stricker. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Young.

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) Home Wife.

(c) Name of employer Herself

9 BIRTHPLACE (city or town) (State or country) Parksley Va.

PARENTS

10 NAME OF FATHER William Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Agnes Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Brother

(Address) 923 W. Franklin.

15 Filed JUL 29 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/29

17 I HEREBY CERTIFY, That I attended deceased from July 25th, 1929, to July 28th, 1929.

that I last saw her alive on July 24th, 1929

and that death occurred, on the date stated above, at 4a m. (Eve)

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Accidental abortion

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Parksley Va.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Test

(Signed) J. T. Gunn M. D.

, 19 (Address) 522 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parsley Va	July 29 1929
20 UNDERTAKER	**ADDRESS**
Dame Earle	916 Pen

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47998

194 E 47998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1700 Whitelock St. (WARD) 43-59

2-FULL NAME Daniel Loyton

(a) RESIDENCE NO. 1700 Whitelock St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Loyton

6 DATE OF BIRTH (month, day, and year) 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O.

(c) Name of employer B. & O.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Loyton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Annie Loyton (Address) 1700 Whitelock St.

15 Filed JUL 29 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 26th 1929 that I last saw h— alive on July 26th 1929 and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

19 (Address) 524 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
White Stone Va	July 30 1929

20 UNDERTAKER Daniel Easton ADDRESS 916 Pa Ave

Spec.—2-29-28—L. F. S.—500 Bks.

924983 E 47999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

154-002

E 47999

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. N-37 WARD)

2—FULL NAME George Doerfler

(a) RESIDENCE NO. 3417 E. Fayette ST. St — WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/12/27

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Doerfler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Strickenter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 29 1929 By HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27-29

17 I HEREBY CERTIFY, That I attended deceased from May 3 1929 to July 27 1929 that I last saw him alive on July 27 1929 and that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:

Pulmonal heart disease
Cerebral thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

(Signed) R Hooper Judd M. D.

July 30 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 30 1929
20 UNDERTAKER	ADDRESS
Lilly & Sons Inc.	400 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 48000

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 942 N. Arguilla ST. 10-W (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary W. von Paris

(a) RESIDENCE NO. 942 N. Arguilla ST., 9 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Eligius von Paris

6 DATE OF BIRTH (month, day, and year) May 30 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward A. Duty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Prosecuting Atty Fire

(Address) 600 E. Hoffman Ave

15 Filed JUL 29 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27/29

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1929, to July 27, 1929, that I last saw her alive on July 25, 1929, and that death occurred, on the date stated above, at 8:20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 3 mos. ? ds.

CONTRIBUTORY (Secondary) Senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Thomas Corcoran M. D.

19 (Address) 100 N. Arguilla

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	July 30 1929
20 UNDERTAKER Tilly & Geidel Inc.	ADDRESS 40 E. Mulberry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

226818

E 48001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 90

E 48001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H. Miller

(a) RESIDENCE NO. Rock Hill S Car ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, ~~widowed~~ or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Cammie Black Miller

6 DATE OF BIRTH (month, day, and year) October 9 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Life Insurance

(b) General nature of industry, business, or establishment in whirh employed (or employer) Equitable Life Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Car.

PARENTS

10 NAME OF FATHER Robt Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Car

12 MAIDEN NAME OF MOTHER Jane White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Car.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 29 1929 19 H. BRYAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28-1929

17 I HEREBY CERTIFY, That I attended deceased from July 2 , 1929, to July 28 , 1929, that I last saw him alive on July 28 , 1929 and that death occurred, on the date stated above, at 9 35 P. m.

The CAUSE OF DEATH* was as follows:

Cutenal Sclerosis

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 14 ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gennal Laboratory

(Signed) Ewing Scopes Smith, M. D.

July 29 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hill S. Co.	July 29 1929
20 UNDERTAKER	ADDRESS
Henry Wenkes Sons	Calvert & Fayette Sts

...E.—WRITE PLAINLY, WITH UNFADING INK. Every ... mation should be carefully supplied. AGE should ... OF DEATH in plain terms, so that it may be pr... important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48002 384 HEALTH DEPARTMENT—CITY OF BALTIMORE. 001 E 48002

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 4-16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Radcliffe

(a) RESIDENCE NO. 1360 Homestead St ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Thomas Radcliffe

6 DATE OF BIRTH (month, day and year) Sept 23 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 071

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Chr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margt Tarr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Beverley Taylor (Address) 1360 Homestead

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D. Registrar Recd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-28-1929

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 28, 1929.

That I last saw her alive on July 28, 1929

and that death occurred, on the date stated above, at 4.15 A m.

The CAUSE OF DEATH* was as follows:

Gangrene, Arteriosclerotic

(duration) yrs. 8 mos. ds.

CONTRIBUTORY: (Secondary) Bronchopneumonia

(duration) yrs. mos. 4-5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes. Date of July 23, 1929

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Fred D. Gill, M. D.

19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stevensville Md.	July 30 1929
20 UNDERTAKER J. B. Nippert 1850	ADDRESS 21 Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

JUL 29 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 48003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48003

1—PLACE OF DEATH

REGISTERED NO. 10-14

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose Schmidt. Sister M. Thadae

(a) RESIDENCE NO. Notre Dame Convent ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Augusta yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) January 15, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adam Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Belty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant School Sisters of Notre Dame

(Address) 901 Aisquith Street

15 Filed JUL 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28-29

17 I HEREBY CERTIFY, That I attended deceased from 7-24-, 19 29, to 7-28-, 19 29,

that I last saw her alive on 7-28-, 19 29

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Acute ruptured gangrenous appendicitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At residence

Did an operation precede death? yes Date of 7-24-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert A. Aenwith, M. D.

7-24-, 19 29 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Md. DATE OF BURIAL July 30 1929

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Eutaw St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 48004

CERTIFICATE OF DEATH

E 48004

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Liberty Road & Dorchester Ave 62 ST.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Florence Louise Graham

(Residence in Baltimore: No. Liberty Road & Dorchester Ave St.; yrs. 6/6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female	W	Married

6 DATE OF BIRTH aug 15, 1898 (Month) (Day) (Year)

7 AGE 30 yrs. 11 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto md

PARENTS

10 NAME OF FATHER Thomas Clark

11 BIRTHPLACE OF FATHER (State or country) Norfolk

12 MAIDEN NAME OF MOTHER Etta Glenn

13 BIRTHPLACE OF MOTHER (State or country) Home de Grace

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. A. Graham

(Address) Liberty Road & Dorchester ave

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 27, 1929 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from November, 1928, to July 27 1929, that I saw h[illegible] alive on July 26, 1929, and that death occurred, on the date stated above, at 5:20 p.m.
The CAUSE OF DEATH* was as follows:

Carcinoma (Cancer).
Left breast
(Duration) 1 yrs. 7 mos. ds
Contributory (SECONDARY) General Carcinoma
(Duration) 1 yrs. mos. ds.
(Signed) [illegible] M. D.
7-29, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New cathedral — DATE OF BURIAL 7-30-1929

20 UNDERTAKER H. Brauning Son — ADDRESS 1156 Poplar grove st

Spec.—2-29-28—L. F. S.—500 Blks.

E 48005 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48005

CERTIFICATE OF DEATH

REGISTERED NO. 27-48

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 607 Lombard ST. Road WARD)

2—FULL NAME Martha Washington Cotter

(a) RESIDENCE NO. 607 Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 5 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Laurence Cotter

6 DATE OF BIRTH (month, day, and year) Feby 22 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS
10 NAME OF FATHER John T. Lyon
11 BIRTHPLACE OF FATHER (city or town) Butte
(State or country) Mont
12 MAIDEN NAME OF MOTHER Julia Scott
13 BIRTHPLACE OF MOTHER (city or town) Butte
(State or country) Mont

14 Informant Harry L. Cotter
(Address) 607 Lombard St

15 Filed JUL 29 1929, 19 ... Registrar
Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28-1929

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to July 28, 1929.
that I last saw her alive on July 27, 1929
and that death occurred, on the date stated above, at 11.00 A m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Colon

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. A. Schaefer, M. D.
(Address) 3610 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL July 30 1929

20 UNDERTAKER H. Thomas & Son — ADDRESS North

C. HAMPSON JONES, M. D.

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48006 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 48006

1—PLACE OF DEATH

REGISTERED NO. 25-77

CITY OF BALTIMORE: (No.) University Hospital (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Guy Fletcher

(a) RESIDENCE NO. 1946 Mosher Ave (ST.) Mt Vernon WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Bargain House

(c) Name of employer

9 BIRTHPLACE (city or town) Grafton

(State or country) West Va

PARENTS

10 NAME OF FATHER Frank Fletcher

11 BIRTHPLACE OF FATHER (city or town) Grafton

(State or country) West Va

12 MAIDEN NAME OF MOTHER Mary Betz

13 BIRTHPLACE OF MOTHER (city or town) Martin burg

(State or country) West Va

14 Informant Frank Fletcher

(Address) 1949 Mosher Ave Mt Vernon

15 Filed JUL 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1929

17

I HEREBY CERTIFY, That I attended deceased from July 24th, 1929 to July 29th, 1929.

that I last saw him alive on July 29th, 1929

and that death occurred, on the date stated above, at 12:20 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia both lobes left lung, lower lobe right lung.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumococcic septicemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) Lewis P. Tendley, M. D.

7-29, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	7-31-1929
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun & Hollins Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 48007

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore, Md. U.S. Marine Hospital (Street) (Ward)

REGISTERED NO. 24-35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Bryans

(a) RESIDENCE NO. 1700 E. Fort Ave., Balto., Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Tashmoo"

9 BIRTHPLACE (city or town) Belfast
(State or country) Ireland

PARENTS

10 NAME OF FATHER John C. Bryans

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Jane C. Kane

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Records, U.S. Marine Hospital
(Address)

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1929

17 I HEREBY CERTIFY, That I attended deceased from June 8 1929 to July 26 1929, that I last saw him alive on July 26 1929, and that death occurred, on the date stated above, at 4:35 P m.

The CAUSE OF DEATH* was as follows:
Tuberculosis, pulmonary

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & clinical finding

(Signed) Ralph L Porter M. D.

7/27, 1929 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Arlington Cem. Washington D.C. DATE OF BURIAL 7/30 1929

20 UNDERTAKER Robert Brooks & Son ADDRESS Calhoun Holaus

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48008

HEALTH DEPARTMENT—CITY OF BALTIMORE

15-001 ✓ E 48008

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. 12-50 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Bowstead

(a) RESIDENCE NO. 2950 Guilmont Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shop foreman.

(b) General nature of industry, business, or establishment in which employed (or employer) R. R. Repair Shops.

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) (State or country) Unknown.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Records

(Address) Baltimore City Hospitals.

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 27, 1929, that I last saw h.. alive on July 27, 1929, and that death occurred, on the date stated above, at 2:20 P m.

The CAUSE OF DEATH* was as follows:

1. Bronchopneumonia

2. Hemiplegia, Rt.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Cerebral Hemorrhage

(duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis? Cerebral hemorrhage.

(Signed) Thomas W. McShane, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 30 1929
20 UNDERTAKER	ADDRESS
Mary M. Maddox	512 E 22nd St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

(Considine)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48009

CERTIFICATE OF DEATH

E 48009

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2609 Barclay St., 12 (Ward) 90

2-FULL NAME Joseph C Considine

(a) RESIDENCE NO. 2609 Barclay St., 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Conglan -

6 DATE OF BIRTH (month, day, and year) Sept 8 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Watchman
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER ~~Ireland~~ James Considine

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan McDonald

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs Margaret Considine
(Address) 2609 Barclay St

15 Filed ..... 19.... C. THAMPSON JONES, M. D. Registrar

JUL 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Arterio-Sclerosis

Myocardial failure (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

Were any conditions discovered? —

Typical Test, Wm H Glades, M. D.
(Signed)
(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Mary Grave	July 31 1929
20 UNDERTAKER	ADDRESS
Mary M Winfield	50 E 32nd St

Spec.—2-29-28—L. F. S.—500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48010

CERTIFICATE OF DEATH

29

E 48010

1—PLACE OF DEATH Madison ave - Bloo...

CITY OF BALTIMORE: (No. Belevieu-Manch... (Street) apts

REGISTERED NO.

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Jules

(a) RESIDENCE NO. Belvieu-Manchester apts

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Jules

6 DATE OF BIRTH (month, day, and year): Oct 18 1857

7 AGE — Years: 70 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Lathuce Neuberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Ellinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lena Jules

(Address) Belvieu Manchester apts

15 Filed ..., 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28/29

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to July 27, 1929

that I last saw h... alive on July 27, 1929

and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dilation

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Harney, M. D.

, 19 (Address) 6 Chase Road

*State the Disease Causing Death, or if death was from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

DATE OF BURIAL: 7/30 1929

20 UNDERTAKER: Abrens Co

ADDRESS: 1929 Division St

JUL 29 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48011

1—PLACE OF DEATH

REGISTERED NO. 1357

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1400 Dellwood Ave ST.) (WARD)

2—FULL NAME Catherine R. Welch

(a) RESIDENCE NO. 1400 Dellwood Ave ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 4 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Welch

6 DATE OF BIRTH (month, day, and year) March 28-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles A. Libby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rose N. Neusbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William J. Welch

(Address) 1400 Dellwood Ave.

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 25 1929. to July 29 1929.

that I last saw her alive on July 29 1929.

and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever
(Malignant Type)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Hiram Dreuen M. D.

7/29 1929 (Address) 846 N 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	July 30 1929.

20 UNDERTAKER Horace H. Burgee ADDRESS 4634 Hills Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

E 48012

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48012

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Dorchester Rd 15-63 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys Cleaon Knabe Slatter

(Residence in Baltimore: No. 3704 Dorchester Rd St.; yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, please fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Dec. 14, 1899. (Month) (Day) (Year)

7-AGE. 29 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE. (State or Country). Baltimore-Maryland

PARENTS.

10-NAME OF FATHER. John Knabe

11-BIRTHPLACE OF FATHER (State or Country). Baltimore-Maryland

12-MAIDEN NAME OF MOTHER. Clara M. Neady

13-BIRTHPLACE OF MOTHER (State or Country). Upton, Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John Knabe (Father)

(Address) 3704 Dorchester Road

15-

Filed ..... 1929 C. HAMPSON JONES, M. D. Registrar.

OCT 29 1929 Pat

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1929. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1929, to July 28 1929, that I saw h[illegible] alive on July 28 1929, and that death occurred, on the date stated above, at 8, A. m.

The CAUSE OF DEATH* was as follows:

Uremia Myelogenous Leukemia

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) [illegible] yrs. mos. 2 ds.

(Signed) Howard H. Warner M. D.

July 28, 1929. (Address) 1604 Harrison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery

DATE OF BURIAL. 7-31-, 1929

20-UNDERTAKER Stewart & Mowen Company

ADDRESS 108-10 North Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This is very important.

Spec.—1-10-21—M&T—1500 Bks.

E 48013 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 48013**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE—(No.) 834 Edmondson Ave (Hospital, Asylum, etc.) — REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Brooks

(a) RESIDENCE NO. 834 Edmondson Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer): Public

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Donald Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Geo. Clarke

(Address) 834 Edmondson Ave

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1928 to July 27th 1929.

that I last saw h[e] alive on July 27th 1929,

and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tub.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Van Ellis M. D.

(Address) 512 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 30 1929

20 UNDERTAKER: Mrs. Geo. H. Kellam ADDRESS 1031 Druid Hill

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48014

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., 11-24 Ward)

2-FULL NAME Oscar Wilson Jr.

(a) RESIDENCE NO. 308 W. Hoffman Ward
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: no.

6 DATE OF BIRTH (month, day, and year): Jan 4-1929

7 AGE — Years | Months: 4 | Days: 23 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Oscar Wilson

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Edith Shelton

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant (Address): Oscar Wilson 308 W Hoffman

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

Per .....

JUL 25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Enteritis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological

(Signed) H. Schaffer M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 7/30/1929

20 UNDERTAKER: Wm. Geo H. Holland — ADDRESS: 1631 Druid Hill

Spec.—1-12-23—M&T—500 Blks.

E 48015 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 48015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Myrtle Ave ... WARD) 20

2-FULL NAME Elvena L. M. Edwards

(a) RESIDENCE NO. 1417 Myrtle ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Edward

6 DATE OF BIRTH (month, day, and year) Mar 3 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	24	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER E. Truman Malloy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER L. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant E. Truman J. Malloy

(Address) 1417 Myrtle Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

JUL 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to July 27, 1929, that I last saw her alive on July 25, 1929 and that death occurred, on the date stated above, at 8.12 P. m.

The CAUSE OF DEATH* was as follows:

Rectal Abcess

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Jan 1929

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Thos Woolridge M. D.

7-29 1929 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL July 31 1929

20 UNDERTAKER Mrs Geo. H. Holland — ADDRESS 1631 Druid Hill

MARKING RESERVED FOR LAMINATING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48016 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48016

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 Gough St. 1-3 WARD)

2-FULL NAME Mary Ann Mason.

(a) RESIDENCE NO. 2213 Gough ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles Mason

6 DATE OF BIRTH (month, day, and year) March 22 18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71.	4.	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Matron

(b) General nature of industry, business, or establishment in which employed (or employer) Church Home Infirmary

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Burke

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Rock

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Jennie Grietta
(Address) 2213 Gough St

15 Filed JUL 29 1929 C. HAMPSON JONES, M. D.
By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 19 29

17 I HEREBY CERTIFY, That I attended deceased from July 23 .19 29 . to July 27 .19 29

that I last saw h[illegible] alive on July 26 .19 29

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

(Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 30-29.
20 UNDERTAKER Woodall & Hippel	ADDRESS 300 E. Columbia

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48017

33 E 48017

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph's St. 12-19 Ward)

2-FULL NAME Mary Jane Hall

(a) RESIDENCE NO. 1621 Latrobe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	52	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Jarrettsville
(State or country) Md.

PARENTS

10 NAME OF FATHER Louis Hall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Amanda Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant John Hall
(Address) Bare Hill Md

15 Filed JUL 30 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1929

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) yrs. mos. 3 Wks

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted — —
If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Physical Tests

(Signed) H. G. Gladden, M. D.

29, 19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harford Co. Md.	July 30, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 323 N Schroeder St

Spec—12-23-21—E.B.&S.—400 Eks.

E 48018

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48018

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 817 Pierce St. 7-26 1929 Registered No.

City of BALTIMORE: (No. 817 Pierce St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Carrol Jones

(a) Residence No. 817 Pierce St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 7/27/29

7-AGE. yrs. mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), 817 Pierce St Baltimore Md.

PARENTS

10-NAME OF FATHER. George Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Emma Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Cookesville Md.

14- (Informant) Mrs. Geo. Carrol Jones

(Address) 817 Pierce St.

15- Filed JUL 30 1929 19 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 27 1929

17- I HEREBY CERTIFY, That I attended deceased from 7/26 1929 to 7/27 1929

that I last saw him alive on 7/27 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Intra-Cranial Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

, 19 (Address) Mun. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Zion Cemetery	July 30, 1929
20-UNDERTAKER.	ADDRESS
Mrs Kate R. Williams	Schroeder St

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

48019.

E 48019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 48019

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Montpelier ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ralph L. Crawford

(a) RESIDENCE NO. 611 Montpelier ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Crawford

6 DATE OF BIRTH (month, day, and year) July 16 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Dr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Andrew J. Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Christina Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Ralph N. Crawford

(Address) 611 Montpelier St

15 Filed JUL 30 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28th 1929

17 I HEREBY CERTIFY, That I attended deceased (from Dec 4 1928 to July 28 1929

that I last saw him alive on July 28 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no

Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy M. D.

7-28 1929 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 30 1929
20 UNDERTAKER	ADDRESS
Chenoweth & Son	3415 Chestnut Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E48020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 48020

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 7-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Kelly

(a) RESIDENCE NO. None ..... ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scrubber

(b) General nature of industry, business, or establishment in which employed (or employer) — 070

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUL 30 1929 19 ... PLATO JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-13 1865, to July 26, 19 29

that I last saw her alive on July 26, 1929

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

..... (duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Senile Dementia

..... (duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Harvin Dell McLean, M. D.

7-27, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 7/31/1929

20 UNDERTAKER J. J. Fahey Sons — ADDRESS 1318 Eight St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48021

CERTIFICATE OF DEATH

+ 199

E 48021

1-PLACE OF DEATH

REGISTERED NO.

City of Baltimore: (No. St. Agnes Hospital 25-72 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Jackson

(a) RESIDENCE NO. Linthicum a. a. Co. Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42		—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab-
(b) General nature of industry, business, or establishment in which employed (or employer) O+D
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Jackson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Wife
(Address)

15 Filed JUL 30 1929 19 H. Pearson Jones M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. base of skull
(Homicide)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. W. Brown M. D.

July 25. 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Ct	7/30/29
20 UNDERTAKER	ADDRESS
Frank L Brown & Co	1700 Montego

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48022

CERTIFICATE OF DEATH.

113 E 48022

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1734 S Charles St. 23-32 Ward)

2-FULL NAME Jos Edward Goldstraw

(a) RESIDENCE NO. 1734 S Charles St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8.12.29

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Jas Raymond Goldstraw

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Mary Eliz Peterson

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country)

14 Informant Mrs Mary Eliz Goldstraw

(Address) 1734 S Charles St

15 Filed JUL 30 1929 19 Pettit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929 7.28.

17

I HEREBY CERTIFY, That I attended deceased from 7.27 1929, to July 28, 1929, that I last saw h.... alive on 7.28, 1929, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis. Colitis. 6 (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Convulsions Edematous 4 hours (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L Dunlington, M. D.

7.29 1929 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial 7/30 1929

20 UNDERTAKER Chas. L. Timmons ADDRESS 1501 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48023

CERTIFICATE OF DEATH.

74-001

E 48023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1833 W. Lombard St. (WARD) 19-26

2-FULL NAME Ida M. Magruder.

(a) RESIDENCE NO. 1833 W. Lombard St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow.

5a If ~~Married, Widowed, or Divorced~~ (of) WIFE of John S. B. Magruder.

6 DATE OF BIRTH (month, day, and year) September 20, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do Not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Fred Hundertmark. (Address) Baker Ave. Parkville.

15 Filed JUL 30 1929, 19 ..... Registrar H. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 28th, 19 29, to July 28th, 19 29, that I last saw her alive on July 28th, 19 29 and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia. (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute dilatation of the Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt, M. D.

7/29, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 7-31 1929

20 UNDERTAKER Bernard C Hartz — ADDRESS 1000 S. PACA ST.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

227228

Col.

E-48024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 48024

PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Coleman

(a) RESIDENCE NO. 1823 N. Duncan ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 9 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single.

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/19/28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Michael Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Marie Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

11 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 30 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-28-29

17 I HEREBY CERTIFY, That I attended deceased from 7-15, 1929, to 7-28, 1929

that I last saw him alive on 7-28, 1929

and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred W. Geil, M. D.

19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross AA Co	7-30 1929
20 UNDERTAKER	ADDRESS
Er B. Harle	115 E West St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48025 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48025

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N Gilmor St., 19-27 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Lenord

(a) RESIDENCE NO. 504 N Gilmor ST., WARD
(Usual place of abode)
Length of residence in city or town where the occurred Life yrs. mos. ds. : How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (WIFE of): Wm Lenord

6 DATE OF BIRTH (month, day, and year): Oct 26, 1906

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
22	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Frank Smith

11 BIRTHPLACE OF FATHER (City or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Lizzie Hall

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 Informant: Lizzie Hall
(Address): 504 N Gilmor St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27, 1929

17 I HEREBY CERTIFY, that I attended deceased from July 25, 1929, to July 27, 1929, that I last saw her alive on July 27, 1929, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W F Howell, M. D.

1929 (Address) 1197 Cornelius Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery

DATE OF BURIAL: 7-30 1929

20 UNDERTAKER: Thomas E. Kelan

ADDRESS: 130 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

L 30 1929

Spec. 2-29-28—L. F. S.—500 Blks.

E 48026

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 48026

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital 15-22 ST. WARD)

2—FULL NAME Maggie Porter

(a) RESIDENCE NO. 1358 N. Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): married.

If married, widowed, or divorced HUSBAND of (or) [redacted] of: Elsie Porter.

6 DATE OF BIRTH (month, day, and year): Sept 22

7 AGE: Years 37 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer): at Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: George H. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary C. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Estella Johnson.

(Address) 620 Baker St.

15 Filed [illegible], 19[illegible] [illegible] JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/26/29

17

I HEREBY CERTIFY, That I attended deceased from 7/20, 1929, to 7/26/29, 1929, that I last saw h[illegible] alive on 7/26/29, 19[illegible] and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bacillus Gangrene of Rt Foot and Broncho pneumonia (duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Amputation Rt Leg Date of 7/24/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Luther E. Little, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 30 19 1929
20 UNDERTAKER Thomas E. Kelson.	ADDRESS 30 Preston St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 48027

CERTIFICATE OF DEATH

E 48027

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Presidential Hosp. 16-23 St. Ward)

2-FULL NAME William McCoy

(a) RESIDENCE NO. 1138 Woodyear St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day and year) 1913-

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
16	15			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School, HH
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country) U

PARENTS

10 NAME OF FATHER Wm McCoy.

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country) U

12 MAIDEN NAME OF MOTHER Ethel Osborne

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Wm McCoy
(Address) 1138 Woodyear

15 Filed JUL 30 1929 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th 1929

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an (Inquest, autopsy or inquiry)

thereon, and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the date stated above, as follows: (Headache)

Hemorrhage due to pistol wound of brain (duration) Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 700 Block School St.

Did an operation preeede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) July 26th Fred Funk, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery.	July 30 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1302 Preston St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REMOVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Blks.

E 48028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 48028

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Temple Garden Apts. ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob M. Frank

(a) RESIDENCE NO. Temple Garden Apts. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sadie H. Frank

6 DATE OF BIRTH (month, day, and year) July 16th. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	68	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia. Pa.

PARENTS

10 NAME OF FATHER Meyer Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Mr. S. Rosenstock

(Address) Frederick, Md.

15 Filed JUL 30 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 19 28, to July 28, 19 29, that I last saw h[illegible] alive on July 28, 19 29, and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Arterio - Sclerosis (duration) yrs. mos. 14 ds.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Emma F. Wagner M. D.

7/30, 1929 (Address) The Esplanade.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Crematory

DATE OF BURIAL 7/30/ 1929

20 UNDERTAKER Baird Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 48029

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Edgewood Ave. St. 20-79 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant of Edna M. & Harry Fitzburger

(a) RESIDENCE NO. 510 Edgewood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 29 1929

7 AGE — Years | Months | Days | If LESS than 1 day 3 hrs or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Harry Fitzburger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Edna M. Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Harry Fitzburger

(Address): 510 Edgewood Ave

15 Filed JUL 30 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29-1929

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to July 29, 1929

that I last saw him alive on July 29, 1929

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) X

(duration) X yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N Lukrauks, M. D.

, 19 (Address) 1340 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park-bem

DATE OF BURIAL: 7/30 1929

20 UNDERTAKER: D. Fenn McCully

ADDRESS: 130 E. Fort.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—4-29/29—L. P. S.—500 Blks.

E 48030 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48030

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 118 W. 23rd ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan Read

(a) RESIDENCE NO. 118 W. 23 ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	M

5a If married, widowed, or divorced (or) WIFE of Jesse Reed

6 DATE OF BIRTH (month, day, and year) Dec 23-66

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	52	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte Va

PARENTS

10 NAME OF FATHER Jerry Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Parthenia Jones

(Address) 118 W. 23 St

Filed JUL 30 1929 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 19 28 to July 28, 19 29

that I last saw h alive on July 28, 19 29

and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home Death

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. Oppenheimer M. D.

, 19 (Address) 2329 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	7-31 19 29
20 UNDERTAKER	ADDRESS
Sam H Chase Sr	1400 Mad

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M.A.T.—1500 Bks.

E 48031

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48031

CERTIFICATE OF DEATH.

118-802

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Smith

(a) RESIDENCE NO. 935 N. Stricker St. ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	M

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Smith

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14. Informant Mary E. Smith (Address) 935 N. Stricker

15 Filed JUL 30 1929 By Hall Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1929

17

I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to July 27, 1929, that I last saw h/ alive on July 27, 1929, and that death occurred, on the date stated above, at 2:50 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of 7/27/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Arthur Rathmell M. D.

7/27/29 Address Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Lutheran — DATE OF BURIAL July 30 1929

20 UNDERTAKER Wm. H. Pause & Son — ADDRESS 1400 N. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48032

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48032

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 18-26

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Bryant

(a) RESIDENCE NO. 811 W. Mulberry st. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Buffalo
(State or country) New York

PARENTS

10 NAME OF FATHER Thomas Givens

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed JUL 30 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan 18, 1929, to July 27, 1929, that I last saw her alive on July 27, 1929 and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Jas Givens M. D.

7-29, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 30, 1929
20 UNDERTAKER Mrs A. A. Elliott	ADDRESS 1725 Carlton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 48033

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Wilkins

(a) RESIDENCE NO. 1721 Ashland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathan Wilkins

6 DATE OF BIRTH (month, day, and year): May 3, 1891

7 AGE — Years: 38 — Months: 4 — Days: 23. — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer): 0?

(c) Name of employer

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER: Peter Harding

11 BIRTHPLACE OF FATHER (city or town): Va.

(State or country)

12 MAIDEN NAME OF MOTHER: Sally Burns

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant: Nathan Wilkins

(Address) 1721 Ashland Ave

Registrar: C. HAMPSON JONES, M.D.

JUL 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rupture of Tube (Preg)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

July 29 1929 (Signed) G. Bayes M. D.

(Coroner)

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. W. Cemetery Date of Burial: July 31 1929

20 UNDERTAKER: W. H. Elliott ADDRESS: 172 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 48034 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48034

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3630 Edmor Road. ST. 9-47 WARD)

2-FULL NAME Mary Kiel

(a) RESIDENCE NO. 3630 Edmor Road. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married.

5a If married, widowed, or divorced (or) WIFE of Emil Kiel.

6 DATE OF BIRTH (month, day, and year) April 1, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, x hrs. or x min.
	75	3.	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none. 31

(b) General nature of industry, business, or establishment in which employed (or employer) none.

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Arbin.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Augusta Mary Zender.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Schumacher

(Address) 3630 Edmor Road

15 Filed JUL 30 1929 C. HAMPSON JONES, M.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to July 28, 1929, that I last saw her alive on July 27, 1929, and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation with Collapse.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Hebron Marston M. D.

7-28 1929 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 31 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Eks.

E 48035 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 48035**

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 1725

CITY OF BALTIMORE: (No. 508 N Paca St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry L. B Downey

(a) RESIDENCE NO. 508 N Paca ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27 61

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Downey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Rauchheim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robert C Downey
(Address) 614 N Fulton Ave

15 Filed JUL 30 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 29

17 I HEREBY CERTIFY That I attended deceased from May 15 . 1929 to July 29 . 1929 that I last saw h-e alive on July 28 . 1929 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage and paralysis June 9/29
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis ?
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S. Willett M. D.

July 30 1929 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	July 31 1929
20 UNDERTAKER H M Rountree	ADDRESS 223 E Pr St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48036

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48036

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 6

CITY OF BALTIMORE: (No. ST. 21-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susie Cole

(a) RESIDENCE NO. 822 Ostend st. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Noedic Cole

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Employe in Tobacco factory
(b) General nature of industry, business, or establishment in which employed (or employer): Tobacco factory
(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Edolin ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed JUL 30 1929 C. HAMPSON JONES, M. D.
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 24, 1929, that I last saw her alive on July 24, 1929, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Jas Edwards, M. D.

7-24-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: July 30 1929

20 UNDERTAKER: Hunter R. Williams — ADDRESS: 22 Ostend st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48037

CERTIFICATE OF DEATH.

129

E 48037.

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... St. 20-27 ... WARD)

2-FULL NAME Mrs. Cathie Sullivan

(a) RESIDENCE No. 1824 W Franklin St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Eugene Sullivan

6 DATE OF BIRTH (month, day, and year) Feb 14 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos Egan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margt McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Daniel Sullivan (Address) 1824 W Franklin St

15 Filed JUL 30 1929 H. HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1929

17 I HEREBY CERTIFY, That I attended deceased from July 27 1929 to July 28 1929 that I last saw her alive on July 28 1929 and that death occurred, on the date stated above, at 12 25 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation X Chronic Nephritis 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. P. Kretschmer M. D.

(Address) 530 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	July 29
20 UNDERTAKER Engelke Funeral Home	ADDRESS 1 W Fayette

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48038

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4816 Gwynn Oak Ave) (Ward 28-6-4)

2-FULL NAME Wm P. Hamilton

(a) RESIDENCE NO. 4816 Gwynn Oak Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) Jan 28 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	5	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Cheltenham Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm H Hamilton

11 BIRTHPLACE OF FATHER (city or town) Kent Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eleanor Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Kent Co
(State or country) Md.

14 Informant Jas E Hamilton
(Address) 4816 Gwynn Oak Ave

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

JUL 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 29th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) July 29th 1929 F. H. Link, M. D. Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 1 1929
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48039

CERTIFICATE OF DEATH

97-002 L

E 48039

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 15-21 ST., WARD)

2—FULL NAME William Benjamin

(a) RESIDENCE NO. 1616 Bruce ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. ? How long in U. S., if foreign birth? — yrs. —mos. —ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace Benjamin

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: James Bruce

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? North Carolina

12 MAIDEN NAME OF MOTHER: Lucy Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Virginia

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed JUL 30 1929 E. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 17, 19 29 to July 23, 19 29

that I last saw him alive on July 23, 19 29

and that death occurred, on the date stated above, at 11:15 A.m.

The CAUSE OF DEATH* was as follows:

Infection of Rt. frontal, antral, ethmoid & sphenoid sinuses

(duration) yrs. 7 mos. ? ds.

CONTRIBUTORY (Secondary) Meningitis (Menningococcus?) determined late (not clinical) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? P.M. Lab. X-ray. Autop.

(Signed) Warren M. McClure, M. D.

7-25, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 30 1929

JUL 30 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48040 ✓ 90 E 48040

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5-6 WARD)

2—FULL NAME Samuel Coleman

(a) RESIDENCE NO. Colvin near Lemington ? ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) ? 67

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Ed Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Louisa Coleman ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Friends
(Address) BALTIMORE CITY HOSPITALS

15 Filed JUL 30 1929, 19 ... Registrar
3285 BALTIMORE CITY HOSPITALS, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-29

17 I HEREBY CERTIFY, That I attended deceased from 6-15, 1929, to 7-29, 1929, that I last saw him alive on 7-29, 1929 and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

over 4½ yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Arteriosclerosis

over 4½ yrs. mos. ds.
(duration)

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P. C. Test

(Signed) Walter M. McLean, M. D.

7-29, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

JUL 30 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48041 CERTIFICATE OF DEATH

31 ✓

E 48041

1—PLACE OF DEATH Baltimore City Hospitals (C.B.) REGISTERED NO. 11-26

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Dixon

(a) RESIDENCE NO. 1107 Edmondson ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or estsblishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Warsaw Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mary Low Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records
(Address)

15 Filed JUL 30 1929 [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1928, to July 27, 1929, that I last saw h.. alive on July 27, 1929 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Jas Glandon M. D.

7-27, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER D. [illegible]

ADDRESS JUL 30 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48042

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 27-55 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Eichelberger

(a) RESIDENCE NO. 5213 St. Charles Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? —yrs.— mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bar keeper

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William H. Eichelberger ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed JUL 30 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from October 31, 19 26 to July 26, 19 29

that I last saw h.. im alive on July 26, 19 29

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

Myocarditis, acute

(duration) yrs. mos. 1 hr.

CONTRIBUTORY (Secondary) Myocarditis, chronic, interstitial (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No autopsy.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Exam.

(Signed) Warren H. McLean, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIV. OF MARYLAND	19
20 UNDERTAKER	ADDRESS
[illegible]	JUL 30 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

22 7608
E 48043

90

E 48043
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Meyer Turow

(a) RESIDENCE NO. 1727 E. Fairmount ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? Unknown yrs. mos. ds.

17 19

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Turow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cloth Presser 80

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Turow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 30 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30-1929

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to July 30, 1929, that I last saw him alive on July 30, 1929 and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

Myocardial failure
Arteriosclerosis

(duration) ? probably several yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Fred W Gilb~~

(Signed) Fred W. Gilb, M. D.

July 30 1929 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL July 30 19 29

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balt St

IMPORTANT—Should be filled out by attending physician, if possible, and should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48044

E 48044

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 533 N. Potomac ST., 1-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter Hagan

(a) RESIDENCE NO. 533 N. Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Hagan

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Hugh Hagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Anna Garnick

(Address) 533 N. Potomac St

15 Filed JUL 30 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 7 19 28 to July 30 19 29

that I last saw h[illegible] alive on July 29 19 29

and that death occurred, on the date stated above, at 2 05 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Chr Int Nephr (duration) yrs. mos. ds.

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Fraum M. D.

1 30 19 9 (Address) 3939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	August 1 1929
20 UNDERTAKER Henry Koeck Sons Co.	ADDRESS 130 E Eager St

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48045

HEALTH DEPARTMENT—CITY OF BALTIMORE

103

188

CERTIFICATE OF DEATH

E 48045

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mind Hosp St. 6-10 Ward)

2-FULL NAME Frances Aug Ellenbock

(a) RESIDENCE NO. 2418 E. Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): 8/20/1920

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or... min.
	8	11	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town): Balto
(State or country): md

PARENTS

10 NAME OF FATHER: John Aug. Ellenbock

11 BIRTHPLACE OF FATHER (city or town): Balto
(State or country): md

12 MAIDEN NAME OF MOTHER: Marie Wimer

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country): md

14 Informant: John August Ellenbock
(Address): 2418 East Fayette Street

15 Filed ..... 19.... HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an Inquest (Inquest, autopsy or inquiry), thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushing fracture left chest
Run down by truck Hacking into
cut

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pul Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Saratoga nr Howard

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Coroner

(Signed) H. Tran M. D.

7/30, 19 29 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	August 1 1929

20 UNDERTAKER: August Tasch ADDRESS: 2406 Ashland Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L 30 1929

Spec.—2-29-28—L. F. S.—600 Bks.

E 48046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 48046

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1822 West Franklin St ST., 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie T. Pattison Jones

(a) RESIDENCE NO. 1822 West Franklin St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Edward Jones

6 DATE OF BIRTH (month, day, and year) April 20th 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER John R. Pattison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ann Timmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Harry E. Ecker

(Address) 5322 Bosworth Ave.

15 Filed JUL 30 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 28th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 17 1929 to July 28 1929 that I last saw h[illegible] alive on July 28 1929 and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of 6

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) E. Heller Hemming, M. D.

7/29, 1929 (Address) 2000 Hollins Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July, 31st 1929

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St

I 30 1929

IMPORTANT—Physicians, Undertakers and Informants are requested to see that OCCUPATION is properly classified. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

227 E 48047 — 63

HEALTH DEPARTMENT—CITY OF BALTIMORE — 124 E 48047

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3744 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard Emmel

(a) RESIDENCE NO. 4710 Harford Ave. — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr Brown Balto Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Emmel

11 BIRTHPLACE OF FATHER (city or town) Md — (State or country)

12 MAIDEN NAME OF MOTHER Anna Alexander

13 BIRTHPLACE OF MOTHER (city or town) Md — (State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

L 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29-29

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to July 29, 1929, that I last saw him alive on July 29, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Edema.
Uremia - Pneumonitis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Fred W Teich, M. D.

19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Aug 1 1929
20 UNDERTAKER	ADDRESS
Frederick Lassahn Sons	Fullerton

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bkn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48048

E 48048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Poplar Grove St. 15-68 WARD)

2-FULL NAME Baby Creamer. (CREAMER)

(a) RESIDENCE. No. 1721 Poplar Grove St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-28-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				7 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1721 Poplar Grove St. Balto. Md

PARENTS

10 NAME OF FATHER Edmund J. Creamer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Bertha Gresham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Born MEMPHIS, TENNESSEE

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUL 30 1929 C. HAMPSON JONES, M. D. Registrar

Reg. 3788

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29 1929

17

I HEREBY CERTIFY, That I attended deceased from 7-28, 1929, to 7-29, 1929, that I last saw him alive on 7-28, 1929, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Premature Labour 27 wks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. Wiser, M. D.

(Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL. DATE OF BURIAL: July 30 1929

20 UNDERTAKER ADDRESS

Gen. Register No.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48049

CERTIFICATE OF DEATH

E 48049

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 514 Gold ST. 14-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs D. Ragland

(a) RESIDENCE NO. 514 Gold St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maud Ragland

6 DATE OF BIRTH (month, day, and year): Nov 20-1880

7 AGE — Years: 48 | Months: 10 8 | Days: 9 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Packer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Mack Ragland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ella Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Maud Ragland

(Address) 514 Gold St

15 Filed JUL 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29/29

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to July 29, 1929.

that I last saw h.... alive on July 29, 1929

and that death occurred, on the date stated above, at 10.55 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Primary)

(duration) yr. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (Real)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hawk E. Virgin M. D.

7/30, 1929 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount DATE OF BURIAL July 31 1929

20 UNDERTAKER: Samuel G Smedley ADDRESS 523 Biddle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48050

CERTIFICATE OF DEATH.

197

E 48050

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital Ward)

2-FULL NAME Charles Thomas

(a) RESIDENCE NO. 323 S. Caroline Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 1909

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Salisbury

(State or country): Va

PARENTS

10 NAME OF FATHER: Wm Thomas

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va

12 MAIDEN NAME OF MOTHER: Laura Thomas

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va

14 Informant: Chas Thomas Uncle

(Address): 323 S Caroline St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1929

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Gun Shot Wound Perforating Abdomen (Duration) 1 hrs. mos. ds.

CONTRIBUTORY (Secondary) Shock (Duration) 1 hrs. mos. ds.

July 29 1929 (Signed) J C Blades (Coroner) M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catonsville Md Date of Burial July 31st 29

20 UNDERTAKER: Spence & Bro by J K Riddle ADDRESS

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L 36 1929

April

Cor.—10-10-29—A Co.—100 Bks.

E 48051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

123

E 48051
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. West Baltomore Gen Hosp St 15-21 Ward)

2-FULL NAME Harold Goldberg

(a) RESIDENCE NO. 2007 Baker St St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 13 2[illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltomore Md

PARENTS

10 NAME OF FATHER Isidore Goldberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillian Kravitz

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Jacl Lewis
(Address) 1439 E, Balto St

15 Filed JUL 31 1929 19 H. MASON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 19 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry)
find that said deceased came to
on the day stated above.
death

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 2009 Baker

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) July 30th 29 H. Klein M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mount Rest	July 31 19 29

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 48052

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48052

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Guilford Ave ST. 11-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John McNeal

(a) RESIDENCE No. 1200 Guilford Ave ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Jan 16, 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
47	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Silversmith

(b) General nature of industry, business, or establishment in which employed (or employer) G.

(c) Name of employer Galdsmith

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Oliver McNeal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Mary Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant John Oliver & the Neal

(Address) 1200 Guilford Ave City

15 Filed JUL 31 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29 1929

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929. to July 29, 1929.

that I last saw him alive on July 29, 1929.

and that death occurred, on the date stated above, at 11-15 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heat

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H Beall, M.D.

, 19 (Address) 112-E Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Aug 1, 1929

20 UNDERTAKER Edmund W. Conklin — ADDRESS 924 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48053 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 48053**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 S. Charles St. ST. 7324 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora L. Mulh

(a) RESIDENCE NO. 1833 S Charles St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Daughter

6 DATE OF BIRTH (month, day, and year) Feb 2, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. V.

PARENTS

10 NAME OF FATHER John Mulh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wend

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Mrs Anna Ernest

(Address) 1833 S. Charles St.

Filed JUL 31 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to July 29, 1929

that I last saw h. alive on July 29, 1929

and that death occurred, on the date stated above, at 8 30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Incidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. L. Campbell M. D.

July 31, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Hill Martinsburg W. V.

DATE OF BURIAL 8/1 1929

20 UNDERTAKER Chas. L. Stevens

ADDRESS 1502 Fort Ave

INFORMATION should be carefully supplied. Any mistake or omission may cause serious delay. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 48054

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 48054

CERTIFICATE OF DEATH

1-PLACE OF DEATH 128 S. Monastery REGISTERED NO.

City of BALTIMORE: (No. 128 St. Ward 20-11)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Nader

(a) RESIDENCE NO. 128 S. Monastery St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 Color or Race: w

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Nader

6 DATE OF BIRTH (month, day, and year): 9/12/1849

7 AGE: Years 79 Months 10 Days 8 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of indostry, bosiness, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Catherine Fitzgerald (Address) 128 S. Monastery

15 Filed JUL 31 1929 16 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/29/1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1927 to July 29, 1929 that I last saw her alive on July 29, 1929 and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) 2½ yrs. mos. da.

CONTRIBUTORY (Secondary) arterio-sclerosis

(duration) 10 yrs. mos. da.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) F. J. Kyper, M. D.

. 19 (Address) 3321 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Date of Burial July 31, 1929

20 UNDERTAKER Chas. W. Dill ADDRESS 3109 Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1924 E 48055

E 48055

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 E. Lombard ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Mary Duffy

(a) RESIDENCE NO. 1824 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced (or) WIFE of: Joseph H Duffy

6 DATE OF BIRTH (month, day, and year): Oct 4 1862

7 AGE: Years 66 | Months 9 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: John Thelen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Mary Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Duffy

(Address): 1824 E Lombard St

15 Filed JUL 31 1924 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29-1924

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1924, to July 29, 1924, that I last saw h[illegible] alive on July 29, 1924, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Heart Prostration

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Coon, M. D.

July 30 1924 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Aug 1 1924
20 UNDERTAKER	ADDRESS
Lilly & Sons Inc.	1003 N Wolfe

MATION should be carefully supplied. Exact statement of OCCUPATION is very
OF DEATH in plain terms, so that it may be properly classified.
important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1941

E 48056

1-PLACE OF DEATH

E 48056

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 441 W. Conway St. 22-30 Ward)

2-FULL NAME Hattie Harrett Rickers Stokes

(a) RESIDENCE NO. 441 W. Conway St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Stokes

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Rickes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Rosie Wharton
(Address) 432 Eislen St.

15 Filed JUL 31 1929 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Stroke

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

7/30, 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8-1 1929
20 UNDERTAKER Samuel Easton	ADDRESS 916 Ba ues

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48057

CERTIFICATE OF DEATH

3/ E 48057

1—PLACE OF DEATH Baltimore City Hospitals (7 B-1) REGISTERED NO.

CITY OF BALTIMORE: (No. 22-31 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Wright

(a) RESIDENCE NO. 111 W. Hughes st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster shucker

(b) General nature of industry, business, or establishment in which employed (or employer) O'g

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Eliza Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Massachusetts

14 Informant Hospital Records

(Address)

15 Filed JUL 31 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 28, 1929, that I last saw her alive on July 28, 1929 and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

Caseous pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Jas Glover M. D.

7-29, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion ct	July 31 1929
20 UNDERTAKER	ADDRESS
A. L. Brown's Son	1058 W. Mt. St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48058

CERTIFICATE OF DEATH

49

E 48058

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto City Hosp. ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Lauchman

(a) RESIDENCE NO. 1112 E. Cambridge ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara

6 DATE OF BIRTH (month, day, and year) ~~March 27~~ 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Adam Fuis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Record

(Address)

15 Filed JUL 31 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/28/29

17

I HEREBY CERTIFY, That I attended deceased from 5/15, 1929, to 7/28, 1929, that I last saw h~~im~~ alive on 7/28, 1929 and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Right Bronchial

Cyst of neck -

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis & Lung.

(duration) yrs 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin, M. D.

7/30, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	July 31, 1929
20 UNDERTAKER	ADDRESS
M. W. E. Ruppal	37 S. Ann

Information should be carefully supplied. Any doubtful statement should be explained. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48059

CERTIFICATE OF DEATH

E 48059

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 882 Washington Blvd ST. OR WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Miller

(a) RESIDENCE NO. 882 Washington Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 3-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. City

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Mary Hirsch
(Address) 882 Wash. Blvd

15 Filed JUL 31 1924 C. HAMILTON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29-1924

17 I HEREBY CERTIFY, That I attended deceased from July 24, 19..., to July 29, 19...

that I last saw h... alive on July 29, 19...

and that death occurred, on the date stated above, at 1.05 a. m.

The CAUSE OF DEATH* was as follows:

Phlebitis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Brunn, M.D.

19 (Address) 217 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 31 19 24
20 UNDERTAKER Wm J Tuckner	ADDRESS Balto Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 48060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168

E 48060

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 6609 Reisterstown Road St. 9-55 Ward)

2-FULL NAME Herschel S. Wetzel

(a) RESIDENCE NO. 6609 Reisterstown Road St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie Wetzel

6 DATE OF BIRTH (month, day, and year): Aug. 9 1873

7 AGE — Years: 55 Months: 11 Days: 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Estate Realtor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Christian Wetzel

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Amanda Strausberger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Father (Address): 6609 Reisterstown Road

15 FILED JUL 31 1929 H. HAMPSON JONES, M. D. Registrar

1009

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and from information received from Inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation, Hanging

Self Inflicted

Suicide!

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. Morrison C. M. D.

(Coroner)

7/30, 1929 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. Date of Burial 1929

20 UNDERTAKER: F. M. Sanford ADDRESS: Mt. Sinai

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48061

CERTIFICATE OF DEATH

90 V

E 48061

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 4-7b WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William New

(a) RESIDENCE NO. 788 Sarah Ann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Va.

PARENTS

10 NAME OF FATHER Robert New

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Va.

12 MAIDEN NAME OF MOTHER Hattie Owen

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Va

14 Informant Records

(Address) TIMORE CITY HOSPITALS

15 Filed JUL 31 1929, 19

THE MOFFUS [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-25-29

17

I HEREBY CERTIFY, That I attended deceased from 7-27, 19 29, to 7-25, 19 29,

that I last saw h[illegible] alive on 7-25, 19 29

and that death occurred, on the date stated above, at 12 5 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Acute.

Endocarditis

B C

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Marvin H. H[illegible] Jr., M. D.

725, 19 29 (Address) MORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible]ETERY.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

[illegible] Commissioner of Health.

JUL 31 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48062

22786

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48062

70

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-47 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leo Krafft

(a) RESIDENCE NO. 503 E. 35th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

.a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 2 1913

7 AGE 16 — Years: 15 | Months: 5 | Days: 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Helper

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Michael Krafft

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eva Gang

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

11 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 31 1929 19 C. HAMPSON JONES, M. D. Registrar

By H. A. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1929

17 I HEREBY CERTIFY, That I attended deceased from July 24 1929 to July 29 1929 that I last saw h m alive on July 29 1929 and that death occurred, on the date stated above, at 10 05 P m.

The CAUSE OF DEATH* was as follows:

Brain abcess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. R. Trimble, M. D.

July 29 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 2 1929

20 UNDERTAKER: George N. Zirkler — ADDRESS: 737 E Eager st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48063 HEALTH DEPARTMENT—CITY OF BALTIMORE

153 E 48063

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Graham

(a) RESIDENCE NO. (Usual place of abode) 1717 N. Bentalou ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER John Graham.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ann Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Chas Dittell

(Address) 1717 N Bentalou St

15 Filed ..., 19 ... Registrar.

HAMILTON JONES, M. D.

JUL 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-29

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to July 30, 1929, that I last saw h.e alive on July 30, 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. 3 mos? ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M B Harding, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arridental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8-1-29
20 UNDERTAKER Martin Fahey & Son	ADDRESS 1617 W North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48064

CERTIFICATE OF DEATH

E 48064

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3524 W Garrison Ave ST., 15-54 WARD)

2—FULL NAME James P O'Bryan

(a) RESIDENCE NO. 3524 W Garrison Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced / HUSBAND of (or) ~~WIFE of~~: Elmira O'Bryan

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 76 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired ~~Laborer~~ Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Patrick O'Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Julia Prendegast

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Rud Miller

(Address) 35-24 Garrison Ave

15 Filed ... 19 ... Registrar

JUL 31 1929 H. [illegible] JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29. 1929

17 I HEREBY CERTIFY, That I attended deceased from May ... 1929, to July 29. 1929, that I last saw h[illegible] alive on July 28 ... 1929, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Nutrial Endocarditis (duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ... (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. H. Enror, M. D.

7-29. 1929 (Address) 4936 Park Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8-1-29
20 UNDERTAKER	ADDRESS
Martin Fahey & Sons	1827 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

E 48065
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101

E 48065
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 209 Rock ST., 18-26 WARD

2-FULL NAME Mrs Lillian Chester

(a) RESIDENCE NO. 209 Rock ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	6	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Day

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Chester

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Lillian Chester
(Address) 209 Rock St

15 Filed JUL 31 1929 HARRY COLE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1929

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to July 24 1929 that I last saw h[illegible] alive on July 24 1929 and that death occurred, on the date stated above, at 11.40 A m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. Calder Fitzsimmons, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	July 31, 1929
20 UNDERTAKER	ADDRESS 3221
Mrs. Katie R. Williams	Schroeder St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48066

CERTIFICATE OF DEATH

100-001 ✓ E 48066

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 E. Lombard ST., WARD) 3-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Griffin

(a) RESIDENCE NO. 843 E Lombard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Griffin

6 DATE OF BIRTH (month, day, and year) dead Nov 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent County Md

PARENTS

10 NAME OF FATHER Day Mobley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent County

12 MAIDEN NAME OF MOTHER Kent Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent County

14 Informant Walter Louise

(Address) 843 E. Lombard St

15 Filed 3 1 1929 C. HAMPSON JONES, M. D. Registrar

Per CWA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/30/29

17

I HEREBY CERTIFY, That I attended deceased from Sat July 27 1929. to Tue Jo , 19 2 ,

that I last saw h alive on 7/29 , 19 29

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Malarkey

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. [illegible] Malarkey, M. D.

, 19 (Address) 1420 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Old Cemetery

DATE OF BURIAL Aug 3 1929

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Pleasant St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 48067 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 48067**

CERTIFICATE OF DEATH.

60-00

1-PLACE OF DEATH Homan's Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Elc. [illegible] Jones

(a) RESIDENCE NO. 1114 West 38th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David F. Jones

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66 yrs.	8 mo.	16 da.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Carroll County Maryland.

PARENTS

10 NAME OF FATHER Isaiah Lockner

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Catherine Henry

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co. (State or country) Maryland.

14 Informant Leroy Edward Jones

(Address) 4019 Evans Chapel Rd

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

JUL 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1929

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to July 29, 1929, that I last saw her alive on July 29, 1929, and that death occurred, on the date stated above, at 9:52 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) Hyperthyroidism

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schork, M. D.

7/29/1929 (Address) Homan's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden. DATE OF BURIAL July 1 1929

20 UNDERTAKER J. Walter Davis ADDRESS 3307 Pine St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 **E 48068**

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1605 E Baltimore St., WARD) 8-13

2—FULL NAME John Thos L Clarke

(a) RESIDENCE NO. 1609 E Baltimore St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie A. Clarke

6 DATE OF BIRTH (month, day, and year) Dec 18 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Packer & exporter

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John L Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto County Md

12 MAIDEN NAME OF MOTHER Birdie Edmonds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Walter G. Hasse

(Address) 2945 Clifton Ave

15 Filed ....., 19 C. HAMPSON JONES, M. D.

21 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1929.

17 I HEREBY CERTIFY, that I attended deceased from July 30, 1929, to July 31, 1929, that I last saw h alive on July 30, 1929 and that death occurred, on the date stated above, at 4 00 A m.

The CAUSE OF DEATH* was as follows:

Extomation & Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Prostate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas Francis, M. D.

July 31 1929 (Address) 4206 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Aug 2 1929

20 UNDERTAKER Hughes & Ford — ADDRESS 1st & Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 48069 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48069

CERTIFICATE OF DEATH

1-PLACE OF DEATH Baltimore Eye, Ear & Throat Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No.) 1214 Eutaw Place ST.: WARD) 11-24 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey I. Silver

(a) RESIDENCE. No. 1214 Eutaw Place ST.. WARD. High Point, N. C.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 7, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) High Point N. C.

PARENTS

10 NAME OF FATHER Milton Silver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lillie Switzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Record
(Address)

15 Filed . 19 . C. HAMPSON JONES, M. D. Registrar

JUL 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to July 31, 1929, that I last saw her alive on July 31, 1929, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Post operative tonsilar hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

17 hrs. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2 P.M.

Did an operation precede death? yes Date of July 30, 1929

Was there an autopsy? no Coloner first gave authority on certificate

What test confirmed diagnosis?

(Signed) Sol Cohen M. D.

. 19 (Address) 1820 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
High Point N C	July 31 1929

20 UNDERTAKER Jack Leuro ADDRESS 1429 E Balt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should s... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

Dr Eisenberg 2027 E North Ave

E 48070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1/3 E 48070

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 N. Bond ST., WARD) 8-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Nelson Baker

(a) RESIDENCE NO. 1116 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 20, 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mable Yeager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Mable Baker

(Address) 1116 N. Bond St

15 FILED 1 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30, 19 29 to July 31, 19 29

that I last saw h m alive on July 31, 19 29

and that death occurred, on the date stated above, at 2:50 p.m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Albert Eisenberg M. D.

7/31/29 (Address) 2025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Aug 1 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

2 E 48071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 90 E 48071

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD) 7-9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr Charles O'Grady

(a) RESIDENCE NO. 1534 Piedmont ST., WARD Charleston W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James O'Grady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sonora Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 3 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1929

17 I HEREBY CERTIFY, That I attended deceased from July 16. 1929 to July 31. 1929

that I last saw h alive on July 31 1929

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Pyonephrosis

Surgical shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & myocardial failure

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home Charleston W Va.

Did an operation precede death? yes Date of 7/31/29

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) Wm. H. Welchey, M. D.

. 19 (Address) John Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charleston W Va	7/31/29
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48072

CERTIFICATE OF DEATH

90 E 48072

REGISTERED NO.

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George H. Frank (Frenk) 15-58

(a) RESIDENCE NO. 2650 Oswego Ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 27 ds. How long in U. S., if foreign birth 67 yrs. 2 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May-4-1862 Single

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Phillip Frenk

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wolly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Germany

14 Informant: Records (Address) BALTIMORE CITY HOSPITALS

15 Filed JUL 31 1929, 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-29-29

17 I HEREBY CERTIFY, That I attended deceased from 6-16, 1922, to 7-29, 1929, that I last saw him alive on 7-29, 1929 and that death occurred, on the date stated above, at 3 20 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

Bronchopneumonia (cause?)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension, Hemiplegia, Left Residual (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C.C.

(Signed) Marvin M. McLean, M. D.

7-30, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Matthews (Cemetery)	Aug 1, 1929.
20 UNDERTAKER	ADDRESS
Edward Mc Cormick & Son	Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

UL 31 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 48073 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **E 48073**

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 E Lexington St. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Goldberg

(a) RESIDENCE NO. 1214 E Lexington ST., WARD 5-E
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth 30 yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Solorkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Paul Goldberg

(Address) 1214 E Lexington st

15 Filed AUG 1 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 | 29

17

I HEREBY CERTIFY, That I attended deceased from Dec. 19 25, to July 31st 19 29.

that I last saw h 4 alive on July 31st 19

and that death occurred, on the date stated above, at 9.9 m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
Arteriosclerosis, Cardiac Hypertrophy,
Arteriosclerosis, Diabetes

and (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory Evidence

(Signed) G. F. Ellis, M. D.

July 31st, 1929 (Address) 24 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel Rd	8/1 19 29
20 UNDERTAKER Sol. Levinson & Bro	ADDRESS 1127 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 48074 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **E 48074**

44

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St., _____ Ward)

2-FULL NAME Lena Ecke

(a) RESIDENCE NO. 1722 Terrell Pl. St. _____ Ward 8-77

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ John H. Ecke

6 DATE OF BIRTH (month, day, and year) Mar 5 94

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Balto

PARENTS

10 NAME OF FATHER Ferdinand Weiss

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Germany

14 Informant John H. Ecke

(Address) 1722 Terrell Pl.

15 Filed AUG 1 1929 C. HAMPSON JONES, M. D.

Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(Duration) 1 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ____ yrs. ____ mos. ____ ds.

July 29, 1929 (Signed) G. C. Gelder, M. D. (Coroner)

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. Date of Burial 8/1 1929

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans St

WHITE PAPER, WITH PARALLEL INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 2-25-28 L. F. S.—500 Blks.

E 48075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 117 ✓ E 48075

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earnest Wright

(a) RESIDENCE NO. Savage Md. ST., WARD D 4-30
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savage Md

PARENTS

10 NAME OF FATHER Frank Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Cris Hebron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk.

14 Informant Mother

(Address) Savage Md

15 Filed OCT 1 1929, 19 H. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/29/29

17 I HEREBY CERTIFY, That I attended deceased from 7/15, 19 29 to 7/29, 19 29

that I last saw him alive on 7/29, 19 29

and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis.
Pericarditis
Mechanical Obstruction

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Savage Md.

Did an operation precede death? Yes Date of 7/15/29-7/29/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical by physician

(Signed) G. J. Warner, M. D.

, 19 (Address) 1 Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Savage Md. —

DATE OF BURIAL Aug 1 — 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 303 Freeman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48076

CERTIFICATE OF DEATH.

159-002

E 48076

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Johns Hopkins Hospital.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. ST., WARD 13-51

2-FULL NAME Baby Tinsley

(a) RESIDENCE Florence Crittendon Home WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26, 1929

7 AGE Years Months Days If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Florence Tinsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Florence Crittendon Home

(Address) Johns Hopkins Hospital

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-26 1929 to 7-27 1929

that I last saw him alive on 7-27 1929

and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

(Pyloric-Congenital

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(durstion) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Gutman M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

JUL 31 19

C. HAMILTON JONES, M. D.

AUG 1 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48077

CERTIFICATE OF DEATH.

161-001

E 48077
REGISTERED NO.

1-PLACE OF DEATH

Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Gamber

(a) RESIDENCE No. Florence Crittenden Home ST., WARD 13-51
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26, 1929

7 AGE Years Months Days If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Leona Gamber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Gamber
(Address) Johns Hopkins Hospital.

15 Filed AUG 1 - 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1929, to 7-26, 1929.

that I last saw alive on 7-26, 1929

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mary Gamber, M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

280

31 19

Spec.—2-29-28—L. F. S.—500 Bks.

227528

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48078

CERTIFICATE OF DEATH

X 161-081 E 48078

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD) 7-9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Hudson

(a) RESIDENCE NO. 1 Stockton Rd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years | Months | Days: 13 | If LESS than 1 day, hrs. or.... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Ruth Hudson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL JOHNS

15 Filed AUG 1 - 1929 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28-1929

17 I HEREBY CERTIFY, That I attended deceased from July 24. 1929. to July 29. 1929. that I last saw him alive on July 29 1929 and that death occurred, on the date stated above, at 2 45 p m.

The CAUSE OF DEATH* was as follows:

1. Prematurity
2. Diarrhea

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?*

(Signed) Ferdinand C. Lee, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very necessary to be properly classified. Every question must be answered in plain terms, so that it may be understood. Do not use abbreviations.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48079 CERTIFICATE OF DEATH

129 E 48079

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Fleet

(a) RESIDENCE NO. 717 N. Hallas ST., WARD 7-13
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

3a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Lottie

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor & Steward

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. —

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15. Filed AUG 1 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29-29

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to July 29, 1929, that I last saw him alive on July 29, 1929, and that death occurred, on the date stated above, at 7 05 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

Probable (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pneumonia, Edema, Myocardial Insufficiency (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ferdinand C. Ce, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner of Health, JUL 31 1929

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48080 — CERTIFICATE OF DEATH — 38 — E 48080

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Kessler

(a) RESIDENCE NO. 128 S. Poppleton ST., WARD 16-29

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Fannie Kessler

6 DATE OF BIRTH (month, day, and year) Unknown 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	about 48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor, painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Kessler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Chepke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Fennie Kessler

(Address) 128 S. Poppleton St.

15 Filed AUG 1 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to July 31, 1929, that I last saw him alive on July 30, 1929 and that death occurred, on the date stated above, at 12.45a m.

The CAUSE OF DEATH* was as follows:

Syphilitic Cardio-vascular disease

(duration) 17 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilitation of Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Kolmer.

(Signed) Minnie C. Canfield M. D.

7/31, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug. 2 1929
UNDERTAKER Rose & Hook	ADDRESS 1003 W. Baltimore St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48081

CERTIFICATE OF DEATH

144 E 48081

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Anita Clarke

(a) RESIDENCE NO. 391 Bells Av ST., WARD 15-63

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 10 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles Edwin Clarke

6 DATE OF BIRTH (month, day, and year) Sept 25. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	10	16	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alonzo Mattox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil Co Md

12 MAIDEN NAME OF MOTHER Maggie Brennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Charles E Clarke

(Address) 391 N Bells Av

15 Filed AUG 1 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29-1929

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to July 29, 1929, that I last saw her alive on July 29, 1929, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Accident of Labor;
Acute Cardiac Dilatation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post partum Hemorrhage, Surgical Shock, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James G. Marston M. D.

7-30, 1929 (Address) 214 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Aug 1 1929
20 UNDERTAKER	ADDRESS
J Dickson Jones	Lo Pa

Do not write in the space below, as this is for property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48082

14-001

REGISTERED NO. E 48082

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Bloomingdale Road WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William John Murphy

(a) RESIDENCE NO. 1216 Bloomingdale Rd. WARD 16-67

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 DATE OF BIRTH (month, day, and year): Dec 17 1855

7 AGE: Years 73 | Months 7 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Cater

(c) Name of employer: Belle City Hotel Co

9 BIRTHPLACE (city or town) (State or country): Howard Co Md

10 NAME OF FATHER: John Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

PARENTS

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma L. Murphy

14 Informant: Mrs Jennie L. Murphy

(Address) 1216 Bloomingdale Rd

15 Filed: 8-1-1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/30/29

17

I HEREBY CERTIFY, That I attended deceased from 7/24, 1929, to 7/30, 1929, that I last saw him alive on 7/30, 1929 and that death occurred, on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of Arteries & Bright's Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. C. Hearn M. D.

7/31, 1929 (Address) 3917 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 2 1929

20 UNDERTAKER: J. Fred Richardson Sons — ADDRESS: 2 Pine

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48083

CERTIFICATE OF DEATH

38

E 48083

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 S. Eutaw ST., WARD) 21-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alberta Robb

(a) RESIDENCE NO. 932 S. Eutaw ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29 19[illegible]

7 AGE: Years 18 | Months 3 10 | Days 1 | If LESS than 1 day,....hrs. or....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): — 0/0

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Robb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Lucy Johnson

(Address) 922 S. Eutaw St.

15 Filed ....., 19.... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25, 29 to July 30, 1929, that I last saw h[illegible] alive on July 29, 1929 and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Epilepsy

Duration (duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

7/31, 1929 (Address) 1908 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: Aug 1st 1929

20 UNDERTAKER: I. H. Brown & Son

ADDRESS: 1018 W. Monument

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48084

CERTIFICATE OF DEATH

194

E 48084
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 Harlem Ave ST., WARD) 17-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth O'Malia

(a) RESIDENCE NO. 828 Harlem Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Peter Lee Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mariah Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Nora O'Malia Branch
(Address) 828 Harlem ave

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29-29

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to July 29, 1929, that I last saw h alive on July 29, 1929 and that death occurred, on the date stated above, at 10 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Intestinal hyperstasis

Acute (Symptom)

Indefinite (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY Mitral Insufficiency
(Secondary)

Indefinite (duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

7-29-1929 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvery cemtery aug 1st	1929
20 UNDERTAKER	ADDRESS
Mr R. A. Elliatt asked me as	

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

137 E 48085

REGISTERED NO.

E 48085

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital WARD 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Miller

(a) RESIDENCE NO. 2802 Huntington ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
(or) WIFE of Harry Miller

6 DATE OF BIRTH (month, day, and year) Feb. 19 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartford Co. Md.

PARENTS

10 NAME OF FATHER Joseph M. Dailey

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Fanny Simms

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant (Address) Hooper Records

15 Filed AUG 1 - 1929 19 H. LEON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/30/29

17 I HEREBY CERTIFY, That I attended deceased from 7. 30, 1929, to 7. 30, 1929

that I last saw h[illegible] alive on 7. 30, 1929

and that death occurred, on the date stated above, at 10:25 A. m.

The CAUSE OF DEATH* was as follows:

Right ovarian cyst with twisted gangrenous pedicle

(duration) yrs. mos. 1 ds. ?

CONTRIBUTORY (Secondary) General Peritonitis, Paralytic Ileus

(duration) yrs. mos. 1 ds. ?

*Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Geo A Baumgartner, M. D.

7/30, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Highland Harford Co	19 29
20 UNDERTAKER Edmondson	ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48086

CERTIFICATE OF DEATH

135

E 48086

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., Caroline and Oliver WARD)

2—FULL NAME Frederick Crispens

(a) RESIDENCE NO. 1253 Rowe Court ST., WARD 4-33
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Crispens

6 DATE OF BIRTH (month, day, and year) Aug 16, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Crispens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Catherine Brunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Frederick Crispens

(Address) 1253 Rowe Court

15 Filed AUG 1 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-29

17 I HEREBY CERTIFY, That I attended deceased from 6-6, 19 29, to 7-31, 19 29, that I last saw h alive on 7-31, 19 29 and that death occurred, on the date stated above, at 6:50 p.m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-11-29

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) W B Hendrix, M. D.

19 Address Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	8/3 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 E Lord Ave

Be DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22 E 7/97 48087

CERTIFICATE OF DEATH

X74-001 E 48087

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD 7-9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Bradley

(a) RESIDENCE NO. Frostburg Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 16 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Jensen

6 DATE OF BIRTH (month, day, and year) 8/30/82

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. W.

(b) General nature of industry, business, or establishment in which employed (or employer) House wife 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Griffith Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER France Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 1 - 1929 W. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1929

17 I HEREBY CERTIFY, That I attended deceased from July 14 . 1929 . to July 31 . 1929 .

that I last saw her alive on July 31 . 1929

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage 24 hrs.

Hypertension, arterio sclerosis, myocardial insufficiency

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) obesity

(duration) 15 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Frostburg, Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Sidney A. Gladstone M. D.

July . 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frostburg, Md

DATE OF BURIAL 8/1 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

48088

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 48088

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 6109 Parkhurst St., Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caracci Joseph Pirraino

(a) RESIDENCE NO. 6109 Parkhurst St. Ward 27-55

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Josephine Piraino

6 DATE OF BIRTH (month, day, and year) 10-15-1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco Importer

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacco

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Vincent

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine ~~Piraino~~ Caracci

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Dr. A. J. Piraino

(Address) 3400 St. Paul St

15 Filed AUG 1929 19

Registrar

G. W. SHOOP NOSDATH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John T. Mogavern M. D.
(Coroner)

7/31 1929 (Address) 3632 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: Aug 2 1929

20 UNDERTAKER: Frank V. Pipitone — ADDRESS: 2815 E. Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48089 CERTIFICATE OF DEATH 38 V E 48089

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Tines

(a) RESIDENCE NO. 158 Hanover St. ST., WARD 4-30
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Ditching, etc. 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee.

PARENTS

10 NAME OF FATHER Henry Tines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee.

12 MAIDEN NAME OF MOTHER Dora ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee.

14 Informant Records of Baltimore City Hospitals.
(Address)

15 Filed AUG 1 1929 J. HAMPTON MOSES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 1929.

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1926. to July 27, 1929.

that I last saw h. was alive on July 27, 1929

and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage. Left: Hemiplegia. etc.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) C.N. 2 Syphilis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann Reaction, Blood C.S.F.

(Signed) Marion Ill McLean, M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS AUG 1 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Duff

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 48090

1—PLACE OF DEATH

REGISTERED NO. E 48090

BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME William Vine Duff

(a) RESIDENCE NO. ..... ST., ... WARD 26-37

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed OCT 1 - 1929 C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-29

17 I HEREBY CERTIFY, That I attended deceased from 10-29, 1925, to 7-31, 1929, that I last saw him alive on 7-31, 1929 and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds. ?

CONTRIBUTORY (Secondary) Arteriosclerosis: Hypertension, Chronic (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Marion W. McLean, M. D.

7-31, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	AUG 1 1929
20 UNDERTAKER Commissioner Health.	ADDRESS

Be sure that every item is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48091

CERTIFICATE OF DEATH

11-60 E 48091

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 W Mulberry ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Brayton

(a) RESIDENCE NO. 540 W Mulberry ST., WARD 17-25
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Col	married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Matthew Brayton

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): General Messenger's

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Thos. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Nellie Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Matthew Bryant

(Address): 540 W. Mulberry St.

15 Filed AUG 1 - 1929 19 H. Fox JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25th, 1929, to July 28th, 1929, that I last saw h alive on July 27, 1929, and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Pancreas (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Barney Warren M. D.

(Address) 908 S. Chapel St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 1, 1929
20 UNDERTAKER: Mrs. Kate R. Williams	ADDRESS 322 N Schroeder St

Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 48092 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 89 E 48092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Patapsco Ave. ST., Brooklyn WARD) REGISTERED NO.

(If death occurred in a hospital or institution give its NAME instead of street and number.)

2-FULL NAME Adam John Miller

(a) RESIDENCE No. 1211 Patapsco Ave. ST. 25-77 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 4 mos. 13 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna T. Miller

6 DATE OF BIRTH (month, day, and year) March 18, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Time keeper at

(b) General nature of industry, business, or establishment in which employed (or employer) Davison Chemical Co.

(c) Name of employer Curtis Bay, Md.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Christian Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna T. Miller

(Address) 1211 Patapsco Ave.

15 Filed AUG 1 1929, 19 H. HARRISON JAMES, M. D., Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30 1929

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to July 30, 1929, that I last saw him alive on July 30, 1929, and that death occurred, on the date stated above, at 11 A. m. The CAUSE OF DEATH* was as follows:

Angina rectoris (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brack M. D.

7-31 1929 (Address) 3601 Third St., Brooklyn, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cemetery DATE OF BURIAL Aug 2 1929

20 UNDERTAKER John F. Denny ADDRESS 715 Light St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48093 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 48093**

CERTIFICATE OF DEATH Raspeburg 90

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 4401 Glenarm Ave WARD) 26-42

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Hughes

(a) RESIDENCE NO. 4401 Glenarm Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

important. See instructions on back of certificates. Every question must be answered. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Hughes

6 DATE OF BIRTH (month, day, and year) May 17 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Patapsco Neck Md

PARENTS

10 NAME OF FATHER John Wesley Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Louise Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Mary E Hughes

(Address) 4401 Glenarm Ave

15 Filed AUG 1 1929 HAMSON JONES, M. D. Registrar

AUG 1 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1929

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 30, 1929, that I last saw him alive on July 30, 1929 and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Cronin M. D.

7.31.1929 (Address) 514 Denny Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 2 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Eighth

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48094 — 194 — E 48094

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Homewood Apts. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma L. Preston

(a) RESIDENCE NO. Charles & 31st ST. S 12-40 WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of James Preston

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel Meakin

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary ---

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant J. Oscar Preston

(Address) Homewood Apts., 6-R

15 Filed AUG 1 1929, 19 — C. HAMPSON JONES, M. D. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31/29

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1929, to July 31, 1929, that I last saw h er alive on July 31, 1929 and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Fatty Adenoma of Thyroid Gld.
Chronic Myocarditis.
Chronic Interstitial Nephritis.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer (duration) yrs. mos. 5. ds.

Heart-Prostration & Uremia

18 Where was disease contracted if not at place of death? at Home death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) John T. Rowe, M. D.

8/1, 1929 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug. 2, 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1900 Eutaw Pl.

Malcolm B. Mitchell

Please fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

226592

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48095

CERTIFICATE OF DEATH

X 49

E 48095

1—PLACE OF DEATH — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2—FULL NAME Robert B. Jackson

(a) RESIDENCE NO. 20 Watauga St Asheville N Car ST., 7-9 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Edward A Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Nannie - Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 1 - 1929 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to Aug 1, 1929, that I last saw him alive on Aug 1, 1929, and that death occurred, on the date stated above, at 6 10 A m.

The CAUSE OF DEATH* was as follows:

Spontaneous Hypoglycaemia
18 mos.
Post-operative 1 day. (Cure)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 9/31/29

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Fred W. Geil, M. D.

8/1, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cuthbert, Ga.	Aug 1 1929
20 UNDERTAKER	ADDRESS
William G. Schaffer	Baltimore

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Holloman.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48096

CERTIFICATE OF DEATH.

90 E 48096

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St.) WARD)

2-FULL NAME Carrie Holloman

(a) RESIDENCE NO. 1067 W Lexington ST., 18-26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Richard Holloman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Blackstone Va.

PARENTS

10 NAME OF FATHER Tom Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Blackstone Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Husband
(Address) 1067 Lexington

15 Filed 1 1929 C. HAMPSON JONES, M. D. Registrar
Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1929

17

I HEREBY CERTIFY, That I attended deceased from July 27. 1929. to July 31. 1929.

that I last saw her alive on July 31 1929,

and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation with hypertension about 6 weeks

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George McDonald, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 8/31 1929

20 UNDERTAKER Geo. Geo. H. Holland — ADDRESS 1661 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48097

CERTIFICATE OF DEATH

43

E 48097

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., WARD)

2—FULL NAME Robert Wright.

(a) RESIDENCE NO. 2413 Druid Hill Ave ST., 13-59 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Wright

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Emory Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed AUG 1 - 1929 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31/29

17 I HEREBY CERTIFY, That I attended deceased from 7/27, 1929, to 7/31, 1929

that I last saw h alive on 7/30, 1929

and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma right side of neck and right side of base of tongue

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary hemorrhage

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) L. U. Lumpkin, M. D.

7/31, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	8/3/1929
20 UNDERTAKER	ADDRESS
Wm. Geo. H. Holland	163 Druid Hill Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48098 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **E 48098**

CERTIFICATE OF DEATH

91-002

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 S. Ellwood ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ann H. Clark

(a) RESIDENCE NO. 815 S. Ellwood ave ST., 1-1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

a If married, widowed, ~~divorced~~ HUSBAND of (or) WIFE of John Clark

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years 69 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary May

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Clark (Address) 815 S. Ellwood ave

15 Filed 1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30-1929

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1929, to July 30, 1929.

That I last saw her alive on July 25, 1929

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. 4 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Caleb N Athey, M. D.

July 31, 1929 (Address) 100 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. | DATE OF BURIAL 8/2 1929

20 UNDERTAKER J. J. Moran | ADDRESS 300 E Baltimore

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48099

CERTIFICATE OF DEATH

194 E 48099

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., Ward)

2-FULL NAME George King

(a) RESIDENCE NO. 5104 Elmer Ave St., 27-56 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Madeline King (nee Ward)

6 DATE OF BIRTH (month, day, and year) June 13, 1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) New York

PARENTS

10 NAME OF FATHER George W. King

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) [illegible]

14 Informant Mrs. Mary M. King
(Address) 5104 Elmer Ave

15 Filed ..., 19... AUG 1 1929 ROSA THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Stroke

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Eugene Zollert M. D.

7/30. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Ridge Cem Frederick Co	Aug 2 19 29
20 UNDERTAKER Harry V. Wittle	ADDRESS 153 W Mulberry St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48100

CERTIFICATE OF DEATH

129 E 48100

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 Cleveland St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia A. Lutz Cline

(a) RESIDENCE NO. 1217 Cleveland St. ST., 21-27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert E. Cline

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	69	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ellis Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Albert E. Cline

(Address) 1217 Cleveland St.

15 Filed 8-1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-29

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 30, 1929, that I last saw h[illegible] alive on July 20, 1929, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Chas. H. Cox, M. D.

7/31, 1929 (Address) 515 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Aug. 3, 1929
20 UNDERTAKER	ADDRESS
Harry L. Dritz & Co.	153 W. Lanvale St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48101

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1839 W. Lombard St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel E. Howard

(a) RESIDENCE NO. 1839 W. Lombard St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Howard

6 DATE OF BIRTH (month, day, and year) July 18, 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62		14	13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Joshua Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Anna M. Howard

(Address) 1839 W. Lombard St.

15 Filed 8-1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1/29.

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Aug 1, 1929, that I last saw him alive on July 31, 1929 and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edgar E. Evans, M. D.

Aug 1, 1929 (Address) Wade Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug. 5, 1929
20 UNDERTAKER Harry A. Wittstadt	ADDRESS Lombard St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48102

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1836 E Pratt ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanislaw Gregorek

(a) RESIDENCE NO. 1530 Eastern Av ST., 3-4 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zofia Gregorek

6 DATE OF BIRTH (month, day, and year) 1886.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Gregorek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Katarzyna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Frank Gregorek

(Address) 1836 Pratt St

15 Filed 1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30/29

17 I HEREBY CERTIFY, That I attended deceased from July 29 19 29 to July 30 19 29 that I last saw h in alive on July 29 19 29 and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma
Myocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? A

What test confirmed diagnosis? Clinical

(Signed) Nathan Wolff M. D.

, 19 (Address) 117 S Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Aug 2 1929
20 UNDERTAKER J W Ozarowski	ADDRESS 1900 Eastern Av

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48103

CERTIFICATE OF DEATH

113 E 48103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. On arrival West Balto Gen Hosp St., Ward)

2-FULL NAME Dorothy Taylor Orban. 15-66

(a) RESIDENCE NO. 3817 Clifton Av St., Ward

(Usual place of abode)

Length of residenea in city or town where death occurred yrs. 8 mos. 10 ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmal	White	Single

5a If married, widowed, or divoreed
HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Nov 21-1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. nr min.
		8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature nf industry, business, or eatablishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Frank J Orban

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Helen Taylor Darby

13 BIRTHPLACE OF MOTHER Montgomery
(State or country) W. Va

14 Informant Frank J Orban
(Address) 3817 Clifton Av

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

AUG 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
topsy or inquiry) find that said deceased came to his death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 3817 Clifton Av

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. C. Smith, M. D.
Aug 1 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	Aug 2 1929
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48104

CERTIFICATE OF DEATH

185

E 48104

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Mahler

(a) RESIDENCE NO. 1813 E. Lombard ST. 2-4 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl 4 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.. Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 87

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob Mahler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record
(Address)

15 FILED 1 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31/29

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 1929, to 7/31, 1929

that I last saw h-er alive on 7/31, 1929

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Fracture neck of right femur

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? City Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) L. U. Lumpkin, M. D.

8/1, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Aug 5 1929
20 UNDERTAKER	ADDRESS
Hughes & Jones Inc	1 E Broadway

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48105 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 14-001 E 48105

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 59 or Bellona Ave ST., WARD)

2-FULL NAME Martha Ann Landerman

(a) RESIDENCE NO. 59 or Bellona Ave ST. 27-48 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of William N. Landerman

6 DATE OF BIRTH (month, day, and year) July 10 - 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	X	20 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Josiah N. Pritchard

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Thatmon

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Randolph Landerman
(Address) 902 Bellona Ave

15 C. HAMPSON JONES, M. D. Registrar
AUG 1 - 1929 . 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 19 29

17

I HEREBY CERTIFY, That I attended deceased from July 22 . 19 29 . to July 31 . 19 29.

that I last saw h[illegible] alive on July 30 . 19 29.

and that death occurred, on the date stated above, at 9 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Arnold, M. D.

8/1, 19 29 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 3 19 29
20 UNDERTAKER	ADDRESS
Hughes & Jones Inc	1 W Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

(Bolden)

E 48106 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **E 48106**

CERTIFICATE OF DEATH

X 40

1—PLACE OF DEATH St Josephs Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Aurelia & Eden St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Boelen

(a) RESIDENCE NO. Middleburg Va ST. 9-17 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Samuel Bolden

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
about	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wesley Wanzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Dr E A Goetting

(Address) Aldie Va

15 FILED 1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-31-29, 19..., to 8-1-29, 19..., that I last saw h alive on 8-1-29, 19..., and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Uremic Intoxication

Duration ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

Duration ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) A B Hunter, M. D.

, 19... (Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middleburg Va	Aug 2 1929
20 UNDERTAKER Franklin W Seitz	ADDRESS 709 W 33 St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48107

CERTIFICATE OF DEATH

159-002 E 48107

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2024 Fleet St. ST., WARD)

2—FULL NAME Mary Tomczewski

(a) RESIDENCE NO. 2024 Fleet St. ST., 2-4 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Tomczewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Stefania Makowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Henry Tomczewski

(Address) 2024 Fleet St.

15 Filed AUG 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

By RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Aug 1, 1929; that I last saw h[illegible] alive on July 30, 1929, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac disease

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P S V S

(Signed) John J. Kluge, M. D.

, 19 (Address) 2627 E. Fleet St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 2 19 29

20 UNDERTAKER ADDRESS

John M. Weber 2218 Eastern

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48108

CERTIFICATE OF DEATH.

162 E 48108

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John:s Hopkin Hosp St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chester Jacubs

(a) RESIDENCE NO. 28 N Streeper St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 17 1929

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chester Jacubs

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Gos

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Chester Jacubs

(Address) 28 N. Streeper St.

15 Filed ..... 19 C. HAMPSON JONES, M. D.

By ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1929

17 I HEREBY CERTIFY that I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Icterus Septicemia

Exhaustion

(Duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

8/1/29 (Signed) H C Bladd M. D.

(Address) 1436 Bway (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Hebr Rosary Aug 2 19 29

20 UNDERTAKER — ADDRESS

John W Weber 701 S Chester St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 1 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48109

CERTIFICATE OF DEATH

159-002

E 48109

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1102 S. Carey ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Iris L. Burns

(a) RESIDENCE NO. 1102 S. Carey ST., 21-29 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John E. Burns

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Iris L. Carey

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant John E. Burns (Address) 1102 S. Carey St.

15 Filed 1-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/31/29

17 I HEREBY CERTIFY, That I attended deceased from 7/29/29, 19..., to 7/31/29, 19..., that I last saw h.. alive on 7/31/29, 19..., and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Heart prostration + Dentitus

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Davis, M. D.

, 19 (Address) 227 N. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	Aug. 2 1929
20 UNDERTAKER	ADDRESS
Wm. C. Miller & Son	2334 Eutaw

G

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Morgan, 708 Reservoir St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓

E 48110

E 48110

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 708 Park Ave or Reservoir ST., WARD)

2—FULL NAME Sarah Rebecca Hay. 70

(a) RESIDENCE NO. 725 Lenox ST. 13-70 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced WIFE of (or) HUSBAND of George M Hay.

6 DATE OF BIRTH (month, day, and year) Nov 14, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Stivers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant G. Morris Hay.

(Address) Edmondson City Md

15 Filed AUG 2 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30. 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/30, 19 29 to 7/30, 19 29 that I last saw her alive on 7/30, 19 29 and that death occurred, on the date stated above, at 6:15 P.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) Several Months

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 725 Lenox St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack J. Morgan M. D.

7/30, 19 29 (Address) Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	August 2 1929
20 UNDERTAKER H. M. Cook	ADDRESS 1217 St Paul

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48117 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48111

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3324 Linn (Fairfield) ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Jennings

(a) RESIDENCE No. 3324 Linn ST., 25 WARD 76

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Daniel Jennings

6 DATE OF BIRTH (month, day, and year) — 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER Horace Burley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mahala. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daniel Jennings

(Address) 3324 Linn St

15 Filed AUG 2 1929 19 Mar. H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1929.

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to July 30, 1929, that I last saw her alive on July 30, 1929, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia —

(duration) yrs. — mos 14 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Plassmeyer, M. D.

, 19 (Address) 3204 Reisterstown St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Aug 2, 1929

20 UNDERTAKER John H. Joachim

ADDRESS 1027 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E. 48112. HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

129 E 48112

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2110 Druid Hill Ave ST., WARD) 50

2-FULL NAME Wm H. Sanks

(a) RESIDENCE NO. 2110 Druid Hill Ave ST., WARD 14

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Sanks

6 DATE OF BIRTH (month, day, and year) June 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Sanks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

July 30 29

14 Informant Annie Sanks

(Address) 2110 Druid Hill Ave

15 Filed AUG 2 - 1929 C. HARRISON JONES, M. D. Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1929

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1929, to July 29, 1929, that I last saw h im alive on July 29, 1929 and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) 1 yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ~~No~~

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S B Hughes M. D.

(Address) 1413 Druid Hill Ave

July 30 29

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 2 1929
20 UNDERTAKER John H. Toadvine	ADDRESS 1047 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48113 ✓ E 48113

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2609 Ailsa Ave ST., Hamilton WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence J Kessler KESSLER 27-44

(a) RESIDENCE NO. 2609 Ailsa Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 10 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Theresa M Kessler

6 DATE OF BIRTH (month, day, and year) Sept 17 1875

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
53	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lawrence Kessler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes Von Schulz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Theresa M Kessler

(Address) 2609 Ailsa Ave

15 Filed AUG 2 1929, 19.. H. McCOY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30/29

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to July 30, 1929.

that I last saw h alive on July 30, 1929

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Rt Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence Smith, M. D.

July 31st, 1929 (Address) 4206 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co	8-3rd 1929
20 UNDERTAKER	ADDRESS
E & B Harle	115 E West St

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48114

CERTIFICATE OF DEATH.

90 E 48114

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John McCafferey 27-56

(a) RESIDENCE NO. 3200 Baltimore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: About 70 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) "

14 Informant Bruce McPherson Neal

(Address) 3200 Balto St

15 Filed ..... 19 ..... H. HAMPSON JONES, M. D. Registrar

G 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

7/21, 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A & Co. Date of Burial 8-2 1929

20 UNDERTAKER: Bernard C Hahn ADDRESS 1000 S Bca

Section should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48115

44 E 48115

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachael Robinson

(a) RESIDENCE NO. Belvedere & Greenspring WARD 27-54

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Robinson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	—	—	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jack Kronthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hinda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Balto St

15 Filed AUG 2 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 1/29

17 I HEREBY CERTIFY, That I attended deceased from July-2- , 1929, to Aug-1- , 1929, that I last saw h[illegible] alive on Aug-1- 1929 and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) about 6 months

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

Aug-2 1929 (Address) 404 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	8/2 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48116

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2031 N Calvert ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm Harry Ramsley

(a) RESIDENCE NO. 2031 N. Calvert ST., 12-19 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Ella Ramsley

6 DATE OF BIRTH (month, day, and year) Feb 22-877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Ofs

(b) General nature of industry, business, or establishment in which employed (or employer) Auto Tires

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER George Ramsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Lillian Ella Ramsley

(Address) 2031 N. Calvert St

15 Filed ..... 19 ..... Registrar

IMPORTANT. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1929

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929. to July 31-, 1929.

that I last saw him alive on July 31-, 1929.

and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis
arterio-Sclerosis, Cardiac Hypertrophy

History (duration) 2 & 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Uremic Convulsion + Coma (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No-

What test confirmed diagnosis? Clinical Exam. + Lab. Tests

(Signed) Howard Bonner, M. D.

July, 1929 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Aug 2 1929
20 UNDERTAKER H. E. Wheeler & Son	ADDRESS Balto Md

HAMILTON JONES, M. D.

AUG 2 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48117

CERTIFICATE OF DEATH

91-002 E 48117

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6000 Belloma Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ann Claggett

(a) RESIDENCE NO. 6000 Belloma Ave ST., 27-48 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

Important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm Henry Claggett

6 DATE OF BIRTH (month, day, and year) Sept 23 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	92	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Bamford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Claggett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant C C Bamford

(Address) 36 ex Woodbine Ave

15 Filed AUG 2 - 1929 HENDERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1929

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to July 30, 1929, that I last saw her alive on July 23, 1929, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

1

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Nachman, M. D.

, 19 (Address) 5835 Gwynn Oak Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Davidsonville Md	Aug 2 19 29
20 UNDERTAKER	ADDRESS
J. J. Graham & Sons	Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48118

CERTIFICATE OF DEATH

74-001

E 48118

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3735 Leo ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward C Turner 25-76

(a) RESIDENCE NO. 3735 Leo ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary C Turner

6 DATE OF BIRTH (month, day, and year) Feb 17-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer 24

(c) Name of employer Self 0

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Caroline Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mary C Turner
(Address) 3735 Leo st.

15 Filed AUG 2 - 1929 G. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30-1929

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to July 30, 1929

that I last saw him alive on July 30, 1929

and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. D. Cobb M. D.

July 31, 1929 (Address) 846-Pennington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 2 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiler INC	403 S Wolfe

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

194

E 48119

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2404 Garrison ave ST., WARD) 15-61

2—FULL NAME Anna M. Helldorfer

(a) RESIDENCE NO. 2404 Garrison ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5-6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Sebastian Helldorfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Regina Heim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John P. Helldorfer

(Address) 2404 Garrison Ave.

15 Filed ..... 19 ..... C. JONES, M. D. Registrar

DEC 7 - 1929 HAMPSON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1929

17 I HEREBY CERTIFY, That I attended deceased from July 19- 1929. to July 31- 1929.

that I last saw h- alive on July 30- 1929

and that death occurred, on the date stated above, at 4- 9.- m.

The CAUSE OF DEATH* was as follows:

Sub-Acute Gastritis-

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Heart Exhaustion-

Cardiac Block (duration) [illegible] ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Dunbar Brantley, M. D.

, 19 (Address) 120 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Dec 3 19 29
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	403 S. Wolfe

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48120

CERTIFICATE OF DEATH

90 E 48120

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 409 N. Caroline ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Richards

(a) RESIDENCE NO. 409 N. Caroline ST., 6-9 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 22-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	27	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Balto Md.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Alex Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Marie Hennige

(Address) 409 N. Caroline St.

15 Filed AUG 2 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to July 31, 1929, that I last saw h... alive on July 27, 1929, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral & aortic regurgitation & Dilatation of Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Articular Rheumatism

(duration) 5 yrs. mos. ds.

18 Where was disease cantracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. J. Smith, M. D.

, 19 (Address) Arnold Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 4 1929
20 UNDERTAKER	ADDRESS
Blair H. Johnson & Co.	Caroline St

Important. See instructions on back of certificates.

Spec.—1-10-23—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48121

CERTIFICATE OF DEATH.

118-00 E 48121

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Womans Hospital ST., WARD)

2-FULL NAME Mary Elizabeth Burke

(a) RESIDENCE NO. 102 Scott St. ST., 18-29 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James M. Burke.

6 DATE OF BIRTH (month, day, and year) June 12. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Charles Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country) France.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Mamie Eliz. Burke.
(Address) 102 Scott St.

15 Filed ..... 19 ..... T. HERBERT JONES, M. D., Registrar

AUG 2 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1929

17 I HEREBY CERTIFY, That I attended deceased from July 29 . 1929 . to July 31 . 1929 .
that I last saw h[illegible] alive on July 31 . 1929 .
and that death occurred, on the date stated above, at 12 50 P. m.

The CAUSE OF DEATH* was as follows:
Paralytic Ileus

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Strangulated gangrenous Hernia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 25, 1929

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Elsie J. Boyle M. D.
. 19 (Address) Womans Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 2nd 1929.
20 UNDERTAKER	ADDRESS
John F. Lowan & Son	90 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48122

CERTIFICATE OF DEATH

129 E 48122

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2023 E. Monument ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T. Tyte

(a) RESIDENCE NO. 2023 E. Monument ST., 7-9 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced: HUSBAND of ~~(or) WIFE of~~ late Catherine Tyte

6 DATE OF BIRTH (month, day, and year): June 14/58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer): Penna. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John T. Tyte

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. May Fleishell

(Address) 2023 E. Monument St.

15 Filed 2-1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30/29

17 I HEREBY CERTIFY, That I attended deceased from March, 1929, to July 30, 1929, that I last saw h alive on July 30 1929 and that death occurred, on the date stated above, at 5 45 P, m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Hypertension Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Lloyd, M. D.

Aug 1, 1929 (Address) 2005 E. Monument St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: Aug 2 1929

19 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48123

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48123

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 526 N. Glover ST., WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Hilsher

(a) RESIDENCE NO. 526 N. Glover St. ST., 7-10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced (or) WIFE of Otto Hilsher

6 DATE OF BIRTH (month, day, and year) Nov 18/1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Duchoslav

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Elizabeth Dostalova

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Henry J. Hilsher

(Address) 526 N. Glover St

15 Filed AUG 2 1929 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31/29

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to July 31, 1929, that I last saw h[illegible] alive on July 30 1929 and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangreen of foot

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? clinical

(Signed) H. C. Eberle M.D.

(Address) 1901 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cem	Aug. 1929
20 UNDERTAKER Philip Herwig	ADDRESS 2516 Eden St.

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48124
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. 802 N Franklin ST., WARD) 12-26
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Hewitt

(a) RESIDENCE NO. 842 W Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Hewitt

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Petersburg, Va

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Lucy Plumber
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Grace Hewett
(Address) 802 W. Franklin St

15 Filed AUG 2 1929 C. HOLTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13 1929, to July 30 1929, that I last saw h[illegible] alive on July 30 1929 and that death occurred, on the date stated above, at 1845 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) [illegible], M. D.
, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk, Va — DATE OF BURIAL Aug 2, 1929

20 UNDERTAKER Mrs. Kate B. Williams — ADDRESS 322 Scheweder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 48125

REGISTERED NO.

1-PLACE OF DEATH 3160 Leeds St

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Moore Holly

(a) RESIDENCE No. 3160 Leeds St ST., WARD 20-70

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence Holly

6 DATE OF BIRTH (month, day, and year) Oct 1-08?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
21		9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Bertha Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wm Moore

(Address) 3160 Leeds St

15 Filed ... 1929 ... HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 28. 1929 to July 30. 1929.

that I last saw her alive on July 30. 1929

and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) 4 hrs 4 mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl + P Exy

(Signed) J. T. Lyser, M. D.

, 19 (Address) 3321 Reed St Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL July 31 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

CAUSE OF DEATH should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48126

CERTIFICATE OF DEATH

129 E 48126

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Lancaster St WARD) 3-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna B. Ruth

(a) RESIDENCE NO. 1516 Lancaster St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J. Ruth

6 DATE OF BIRTH (month, day, and year) Feb 8 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cuba

PARENTS

10 NAME OF FATHER William Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Phillbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hanora Smith

(Address) 516 Lancaster St

15 Filed ....., 19.... C. PAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-1-1929

17 I HEREBY CERTIFY, that I attended deceased from July 31, 1929, to July 31, 1929

that I last saw h[illegible] alive on July 31, 1929

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Uremic Toxemia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Path. Jos. H. Valentine, M. D.

(Address) 14 So Kennedy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathal	Aug 3 1929
20 UNDERTAKER	ADDRESS
Jos. W. E. Deppe & Son	31 Lexington W

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48127

CERTIFICATE OF DEATH

1-001 E 48127

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Kowalewski

(a) RESIDENCE NO. 2913 Dillon ST., 1-1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S.. If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 28 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Kowalewski

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Brown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed AUG 2 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to Aug 1, 1929, that I last saw her alive on Aug 1, 1929 and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.C. Test

(Signed) Marvin M. McLean, M. D.

8-1, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Aug 3 1929
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski Inc	5000 Kenwood Ave

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 48128

CERTIFICATE OF DEATH. 31 E 48128

1-PLACE OF DEATH

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 822 E. Eager ST., WARD)

2-FULL NAME Daniel V. Daily

(a) RESIDENCE NO. 822 E. Eager ST., 10-14 WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
32	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Andrew Ireland Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Timothy Daily

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Sundrad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Timothy Daily Father
(Address) 822 E. Eager St.

15 Filed AUG 2 - 1929, 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929. to Aug 1, 1929.
that I last saw h— alive on July 29, 19—,
and that death occurred, on the date stated above, at 6 a— m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yr. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Catlin Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Faulkner, M. D.
8/1, 19 29 (Address) Tower Chambers

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. | DATE OF BURIAL Aug 5 1929

20 UNDERTAKER Elmer W. Conklin | ADDRESS 944 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 48129 REGISTERED NO.

E 48129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hosp. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Henrietta D. P. Ruark

(a) RESIDENCE No. 3057 Brighton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
or) ~~WIFE of~~ John E. Ruark

6 DATE OF BIRTH (month, day, and year) Nov 3, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~65~~	65	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Laughton

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Pearson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr John E Ruark (Husband)
(Address) 3057 Brighton st

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1929. to Aug 1, 1929.

that I last saw her alive on July 31, 1929. 19

and that death occurred, on the date stated above, at 3.00 A m.

The CAUSE OF DEATH* was as follows:

~~Brain abscess~~

Cerebral Apoplexy. Generalized arterio sclerosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug 3 1929
20 UNDERTAKER	ADDRESS
W. A. Emory	715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 2 1929 HARRISON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

E 48130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 E 48130

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2643 ST., WARD)

2-FULL NAME Thomas M Keys

(a) RESIDENCE NO. 2643 N. Calvert St. ST., 12-50 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Lenorance G. Keys

6 DATE OF BIRTH (month, day, and year): Oct 13 1847

7 AGE — Years: 51 Months: 10 Days: 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Proprietor of Hotel

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: Hugh Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Md

12 MAIDEN NAME OF MOTHER: Matilda Freeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Charles Keys (Address) 2643 N. Calvert

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

AUG 2 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 28th. 1929. to August 1. 1929.

that I last saw h[illegible] alive on August 1. 1929.

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Uremia - Nephritis

Contributory (Secondary) Pulmonary Edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hamden D. Crum, M. D.

(Address) 2827 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL—CREMATION OR REMOVAL: Mt Lebanon Freeland Balto. — DATE OF BURIAL: Aug 3, 1929

UNDERTAKER: A. S. Marshall 3539 — ADDRESS: Fall Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48131

CERTIFICATE OF DEATH

129 E 48131

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Cathedral ST., WARD) 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert B. Smith

(a) RESIDENCE NO. 1007 Cathedral St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 16 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Katharine Klug

6 DATE OF BIRTH (month, day, and year) March 17, 1857

7 AGE	Years	Months	Days 14	If LESS than 1 day, hrs. or min.
	72	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Jessie McFee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs. Katharine K. Smith

(Address) 1009 Cathedral St.

15 AUG 4 - [illegible] C. HAMPSON ELKINS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1-29

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to Aug 1, 1929, that I last saw him alive on Aug 1, 1929 and that death occurred, on the date stated above, at 9.40a m.

The CAUSE OF DEATH was as follows:

Pulmonar Heart Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

Uremia (duration) yrs 13 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? all —

(Signed) Dr J Thomas Gibson, M. D.

, 19 (Address) 1001 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: August 3, 1929

20 UNDERTAKER: Henry H. Wears & Son — ADDRESS: 805 N Calvert

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 48132

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3309 Liberty Heights St. Ave. WARD 61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Allston Jones

(a) RESIDENCE NO. 3309 Liberty Heights St. Ave. WARD 15

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice Block

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	33	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales

(b) General nature of Industry, business, or establishment in which employed (or employer) Manager

(c) Name of employer Jones Nash Motor Co.

9 BIRTHPLACE (city or town) [redacted]. Matthews Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Walter Jones

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Carrie Darnell

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Virginia

14 Informant Mrs. Beatrice B. Jones

(Address) 3309 Liberty Heights Ave.

15 Filed ... 19 ... HAROLD L. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31/1929

17 I HEREBY CERTIFY, That I attended deceased from July 22. 1929. to July 31. 1929.

that I last saw h-- alive on July 31. 1929

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H L Kilpatrick M. D.

Aug 2. 1929 (Address) Westwood apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/3 19 29

20 UNDERTAKER Henry W. Deas and Son ADDRESS 505 N. Calvert

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48133

CERTIFICATE OF DEATH

194 E 48133

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Archer ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Belle Nelson

(a) RESIDENCE NO. 628 Archer ST., 21-29 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Nelson

6 DATE OF BIRTH (month, day, and year): Dec

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Jane Moss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Sadie Edsall

(Address) 628 Archer St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/1/29

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 19 29, to 8/1, 19 29, that I last saw h... alive on 8/1, 19 29, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary): Heart Disease

old age (duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hampson Jones M. D.

, 19 (Address) 2 W Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 3 1929
20 UNDERTAKER	ADDRESS
C. L. Brown's Son	1110 W. Mary

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48134

CERTIFICATE OF DEATH

31 E 48134

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James (Harry) Thomas

(a) RESIDENCE NO. 513 W. Cross st. ST., 21-31 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caretaker

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 2-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 30, 1929, that I last saw him alive on July 30, 1929 and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Caseous pneumonia

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) [signature] M. D.

7-30, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Aug 2 1929

20 UNDERTAKER Joseph A. Sively & Sons ADDRESS Mount

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 48135

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48135

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3406 W. Franklin ST., WARD) 20-70

2-FULL NAME Mary A. Cousins

(a) RESIDENCE NO. 3406 W. Franklin St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wh	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard P. Cousins

6 DATE OF BIRTH (month, day, and year) Aug 15, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) / / / /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mary A. Cousins

(Address) 3406 W. Franklin St

15 Filed 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1929

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to August 1, 1929.

that I last saw her alive on Aug 1, 1929,

and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) L. A. Lally, M. D.

, 19 (Address) 35 N Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery Aug 3 1929

DATE OF BURIAL

20 UNDERTAKER Fred A. Evans & Son

ADDRESS 703 Hanover

CAUSE OF DEATH in plain terms, so that if may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

22768

2 E 48136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 48136

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2—FULL NAME Fannie Bresse 3-5

(a) RESIDENCE NO. 312 S. High ST., St 3 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant.

6 DATE OF BIRTH (month, day, and year): March 12 1929

7 AGE: Years — Months: 7 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: baby

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER: Charles Bresse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Ella Francesse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed: 2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31-29

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to July 31, 1929.

That I last saw her alive on July 31, 1929

and that death occurred, on the date stated above, at 10 25 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4- ds.

CONTRIBUTORY (Secondary) Gastroenteritis

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Wm. W. Nail, M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 3. 1929.
20 UNDERTAKER	ADDRESS
Wendell & Hyppd.	300 Eden St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48137

X 1-001 ✓

E 48137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., Ward)

2-FULL NAME Enid Miller

(a) RESIDENCE NO. Locke Raven Rd St., Ward 7-9

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Wife, Vernon Miller

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28	4 March	11 20 1901	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Jno Owens

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Lola Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Vernon Miller
(Address) Locke Raven

15 Filed 2-1929 19 C. THAMPSON JONES, M. D. Registrar
By ARN

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Typho-Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? — Date of —

Was there an autopsy? Just

What test confirmed diagnosis? Clinical Evidence

Aug 9 1929 (Signed) Geo. E. Wades, M. D.

(Address) 1431 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Jefferson Md	Aug 12, 29
20 UNDERTAKER John Burns Sons	ADDRESS Towson Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48138

CERTIFICATE OF DEATH

188-203 E 48138

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Agns Hosp St., Ward)

2-FULL NAME Fred'k A. Cook

(a) RESIDENCE NO. Frosmps Mill St., 25-72 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Cook

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tool Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Dont know

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant (Address) St Agns Hosp

15 Filed ..... 19.....

AUG 2 - 1929

C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) 8-1-1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Compd. R. Leg & Pericardium
Direct Skull fracture due to being
run down by automobile
on Wash. Blvd (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Int Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lamm Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Lamm M. D.

8/2 1929 (Address) 2939 W Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 8/5 1929

20 UNDERTAKER Kopf & Kaiser — ADDRESS Lanvale

Cause should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 182 E 48139

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Harbor Hosp. Clinics St., Ward)

2-FULL NAME Bruno H Anderson 26-36

(a) RESIDENCE No. S.S. Gustavsholm St., Ward Sweden

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20 - 1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer S/S Gustavsholm

9 BIRTHPLACE (city or town)
(State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant W. M. Hurley
(Address) 19 South St

15 Filed 12-1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:

Acc Drowning

(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What are the conditions diagnosed?

(Signed) H. Stader, M. D.

(Address) 43 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hamden — DATE OF BURIAL Aug. 3 1929

20 UNDERTAKER Wm Cook — ADDRESS 121 W Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-20-28—L. F. S.—500 Blks.

E 48140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48140

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST., ____ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sumner Fletcher

(a) RESIDENCE NO. 713 Dover ST. 22-29 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	45 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Maryland

PARENTS

10 NAME OF FATHER: John Fletcher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co. Maryland

12 MAIDEN NAME OF MOTHER: Marian Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Chestertown Maryland

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed ____, 19 ____ C. HAMPSON JONES, M. D. Registrar

Important. Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929 to August 1, 1929

that I last saw him alive on August 1, 1929

and that death occurred, on the date stated above, at 12:35 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute, c insufficiency

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Syphilis

Chronic Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? CC

(Signed) Marvin M. McLean, M. D.

8-2, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md.	Aug 3rd 29
20 UNDERTAKER: Samuel L. Kenney	ADDRESS: Biddle

2-1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 48141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 48141

1—PLACE OF DEATH: Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: Clinton Wright

(a) RESIDENCE NO. (Usual place of abode): 2024 McCulloh ST., 14-20 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. ? How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Elizabeth Wright~~ Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Houseman

(b) General nature of industry, business, or establishment in which employed (or employer): Waiter 070

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Towson, Maryland

PARENTS

10 NAME OF FATHER: Al Wright ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland or Va ?

12 MAIDEN NAME OF MOTHER: Frances Johnson ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland or ?

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

B - 1929 - 87 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929 to August 1, 1929

that I last saw him alive on August 1, 1929

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Diffuse

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary): Syphilis; Arteriosclerosis ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Path. Lab

(Signed) Marvin M. McLean, M. D.

(Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem.	Aug 5 1929
20 UNDERTAKER	ADDRESS
Elvie N. Johnson	416 N. Carrollton Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48142 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 48142

CERTIFICATE OF DEATH

45

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2822 N. Calvert ST., WARD)

2—FULL NAME Emily G. Tate

(a) RESIDENCE NO. 2822 N. Calvert ST., 12-50 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Tate

6 DATE OF BIRTH (month, day, and year) May 25, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	7 6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William J. Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Gladding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph Tate

(Address) 2822 N. Calvert St.

15 Filed AUG 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from July 29th, 1929, to Aug 1st, 1929, that I last saw her alive on Aug 1st, 1929 and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) tom

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? signs & symptoms.

(Signed) J. A. Blatand, M. D.

Aug 2nd, 19 29 (Address) 1300 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug. 3, 19 29

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Mahlon E. Mitchell

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48143 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 48143

44

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4002 Edmondson Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hugh Auld

(a) RESIDENCE NO. 4002 Edmondson Ave. ST. 16-71 WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~ Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Wood

6 DATE OF BIRTH (month, day, and year): Dec. 5, 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
67	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supt. Balto.

(b) General nature of industry, business, or establishment in which employed (or employer): Post-office

(c) Name of employer: branch

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Benjamin F. Auld

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Miss Harriet Auld

(Address): 4002 Edmondson Ave.

15 Filed 8-3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1928 to Aug 1st 1929 that I last saw him alive on July 31 1929 and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of May 7 1928

Was there an autopsy? Yes

What test confirmed diagnosis? Op & autopsy

(Signed) Chas. W. Cunningham M. D.

8/2 1929 (Address) 9 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug. 3, 1929

20 UNDERTAKER: John O. Mitchell & Sons — ADDRESS: 1900 Eutaw Pl.

Malcolm B. Mitchell

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 48144 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48144

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Woman's Hospital ST., WARD)

2-FULL NAME Susan Macy Marr

(a) RESIDENCE NO. 605 St. Paul ST., 11-7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? ✓ yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Marr.

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Hampton (State or country) Virginia

PARENTS

10 NAME OF FATHER William D. Macy

11 BIRTHPLACE OF FATHER (city or town) Nantucket Island (State or country) Mass.

12 MAIDEN NAME OF MOTHER Marilla Caverno

13 BIRTHPLACE OF MOTHER (city or town) ✓ (State or country) New Hampshire

14 Informant Marjorie C. Marr (Address) 605 St. Paul St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2 19 29

17

I HEREBY CERTIFY, That I attended deceased from July 11, 19 29 to August 2 19 29, that I last saw her alive on August 2, 19 29, and that death occurred, on the date stated above, at 6.42 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ✓ yrs ✓ mos 2 da.

CONTRIBUTORY (Secondary) Cardiovascular renal disease

(duration) ✓ yrs mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph L. Schork M. D.

19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 5 19 29

20 UNDERTAKER John O. Mitchell & Sons ADDRESS 703 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3 1920

Spec.—1-12-23—M&T—500 Blks.

E 48145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88 E 48145

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 N. Stricker ST., WARD)

2-FULL NAME Jessie Connor

(a) RESIDENCE NO. 312 N. Stricker ST. WARD 19-27
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Cal

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): [illegible] 1869

7 AGE: Years 60 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Saloon
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Eula Waters
(Address) 312 N. Stricker

15 Filed 1929, 19 Mar 3

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-1-1929

17

I HEREBY CERTIFY, That I attended deceased from 6-20, 1929, to 8-1-, 1929.

that I last saw h[illegible] alive on 7-28-, 1929.

and that death occurred, on the date stated above, at 8:10 a m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho-pneumonia
Acute pulmonary tuberculosis
Cerebral metastasis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Acute Bacterial endocarditis

(duration) yrs. 1 mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hanson, M. D.

8/1, 1929 (Address) Noon Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: Aug 3 1929

17 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Hanover

G

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48146

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48146

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Division ST., WARD)

2-FULL NAME Austin Wheeler

(a) RESIDENCE No. 1612 Division ST. 14 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Wheeler

6 DATE OF BIRTH (month, day, and year) March 3, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer B & O Railroad

9 BIRTHPLACE (city or town) (State or country) Worsaw Va.

PARENTS

10 NAME OF FATHER Daniel Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Danville Va

12 MAIDEN NAME OF MOTHER Harriet Woody

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Worsaw Va.

14 Informant Mary Wheeler (Address) 1209 Pennsylvania Ave

15 Filed 8-1929 G. HAMPSON JONES, M. D. Registrar By HH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 31 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927 to June 31, 1929, that I last saw him alive on June 30, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Cerebral Hemorrhage) (duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1612 Division

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Thos H Wright M. D.

(Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 8-3 1929

20 UNDERTAKER Samuel D Kemp — ADDRESS 578 Reade

TION is very important See instructions on back of certificates.

Cause of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

3

Spec.—1-12-23—M&T—500 Blks.

E 48147

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48147

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1141 N Studer ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jones

(a) RESIDENCE NO. 1141 N Studer ST., 16-22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj Jones

6 DATE OF BIRTH (month, day, and year) May 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Nathaniel Meeks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Betsy Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Lillian Brooks

(Address) 1141 N Studer St.

15 Filed G 3 1929. 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3 1929

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to August 2, 1929, that I last saw h[illegible] alive on August 3, 1929, and that death occurred, on the date stated above, at 3:45 A m.

The CAUSE OF DEATH* was as follows:

Acute Leucocytosis

(duration) yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary)

Diabetes Mellitus (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 3

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Luther A Tuttle, M. D.

, 19 (Address) 1137 Tiel St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Cemetery DATE OF BURIAL Aug 5 1929

20 UNDERTAKER [redacted] ADDRESS [redacted] Balto Md

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Eks.

E 48148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002 E 48148

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maude Taylor

(a) RESIDENCE NO. 218 N. Potts Ave. Ward 16.26

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col'd	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 30 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
23	24	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo Robinson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Emma

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Sarah Grayson
(Address) 218 N. Potts Ave

15 Filed ..... 19.....

3 - 1929

O. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 31st 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 31st

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Blenkinsop M. D.

Aug 1st 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Aug 3 29
20 UNDERTAKER	ADDRESS 32 N. Schroeder St.
Mrs Katie R. Williams	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 48149

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48149

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1600 N. Bentalou ST., WARD) 21

2-FULL NAME Morris Altschuler

(a) RESIDENCE NO. 1600 N. Bentalou ST., WARD 15

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Pauline Altschuler

6 DATE OF BIRTH (month, day, and year): Dec 11-1886

7 AGE: Years 42 | Months 9 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Benj. Altschuler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dora ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Pauline Altschuler (Address) 1600 N. Bentalou

15 Filed C. HAMPSON JONES, M. D. Registrar

8 - 1929 By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2 1929

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929 to Aug 2, 1929

that I last saw him alive on Aug 2, 1929

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clin. Exam.

What test confirmed diagnosis?

(Signed) Louis T. Levy, M. D.

8/3, 1929 (Address) 1740 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Pk

DATE OF BURIAL: 8/5 1929

18 UNDERTAKER: Jack Lurz

ADDRESS: 1439 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 48150 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48150

135

1-PLACE OF DEATH Sinai Hosp.

CITY OF BALTIMORE: (NO. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel A. Metzger

(a) RESIDENCE NO. Esplanade Apts ST. 13-59 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annette L. Metzger

6 DATE OF BIRTH (month, day, and year): Feb 28 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Ladies Apparel

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Aaron Metzger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Dettie Hamburger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Allen Metzger (Son) ~~Balto~~ 330 N Chas St.

15 Filed Aug 3 1929 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to Aug 2, 1929, that I last saw him alive on Aug 2, 1929, and that death occurred, on the date stated above, at 9.55 P m.

The CAUSE OF DEATH* was as follows:

1. Benign Hypertrophy of Prostate
2. Ventriculum of Bladder
3. Hemolytic Staphylococcus Septicemia
4. Myocardial failure

(duration) yrs mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? Yes Date of July 26, 1929

Was there an autopsy? No

What test confirmed diagnosis? Usual tests.

(Signed) Benj F Whitehouse, M. D.

, 19 (Address) 330 N Chas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bell. Hebrew Cem. DATE OF BURIAL 8/5 1929

20 UNDERTAKER: David Sondheim ADDRESS 518-20 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

33

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48151

CERTIFICATE OF DEATH

129 E 48151

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 N. Durham ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nella Johnson

(a) RESIDENCE NO. 913 N. Durham ST. 7-B WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

a If married, widowed, or divorced (or) WIFE of John Johnson

6 DATE OF BIRTH (month, day, and year) Oct 24, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41	42	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work Home 037

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John H. Dekind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Alberta Hilliard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Laura Scott (daughter)
(Address) 913 N Durham St

15 Filed 3-1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1929. to July 31. 1929.
that I last saw her alive on July 31. 1929
and that death ocrurred, on the date stated above, at 10.45 P.M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Sous Negligible to Generalized Sclerosis (duration) yrs. 6 mos. ds.

18 Where was disease contrarted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. F. Young M. D.

8/1 1929 (Address) 1429 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cem.	8-3rd-29
20 UNDERTAKER	ADDRESS
Byron & Wright	1218 N. Calderon St

IMPORTANT.—See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 48152 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48152

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 650 W. Lee ST., 22 WARD)

2-FULL NAME Hannabell ~~Toones~~ Joines

(a) RESIDENCE No. 650 W. Lee ST., 22 WARD 22-30

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raleigh N. C.

PARENTS

10 NAME OF FATHER Tilman Joines

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Clara Stanley (Address) 650 W. Lee St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/2/ 1929

17

I HEREBY CERTIFY, That I attended deceased from 7/30/ 1929, to 8/2/ 1929, that I last saw h[illegible] alive on 8/1/ 1929, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema
Aortic Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. ~~20~~ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical + History

(Signed) C. H. Jones, M. D.

19 (Address) 729 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery — DATE OF BURIAL 8/4 1929

20 UNDERTAKER Walter R. Lynch — ADDRESS 1317 Hamburg St.

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48153 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ E 48153

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Stanford

(a) RESIDENCE NO. 911 N. Caroline ST. 7-13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Stanford

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
36	37	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer) Owen's Rock

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Port of Spain Trinidad West Indies

PARENTS

10 NAME OF FATHER Benjamin Stanford

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) West Indies

12 MAIDEN NAME OF MOTHER Martha Branham

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) West Indies

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed 8-3-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to 8-1, 1929, that I last saw h.. alive on 8-1, 1929 and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Toxemia

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy: P.C.

(Signed) Marvin M. McLean M. D.

8-1, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Aug. 4 1929
20 UNDERTAKER	ADDRESS
Mrs J. G. Locke	1302 Jeffers

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48154 ∴

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48154

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1938 Harlem ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa B Buhrman

(a) RESIDENCE NO. 1938 Harlem ave ST., 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 DATE OF BIRTH (month, day, and year) Nov 1 87

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jonstown (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Halland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Lauzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Phares E. Buhrman

(Address) 1938 Harlem ave

15 Filed 3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2-1929

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to Aug 2, 1929, that I last saw h alive on Aug 2, 1929 and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

{ Myocardial Insuff }

{ Hypertension

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma & Emphy

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Phy. Exam

(Signed) Henry C. Todd, M. D.

8/2, 1929 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Graceham Frederick Co Md	Aug 1929
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. Fort Ave

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48155

CERTIFICATE OF DEATH.

90 **E 48155**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2232 Oak. St. 12 Ward)

2-FULL NAME Frank. F. Lewis 51

(a) RESIDENCE NO. 2232 Oak st St. 12 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Columbia H Lewis

6 DATE OF BIRTH (month, day, and year) July 8 1840

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	89	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Batavia

(State or country) New York

PARENTS

10 NAME OF FATHER Jacob Lewis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Batavia N. Y.

12 MAIDEN NAME OF MOTHER Anna Maria Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York

14 Informant Mrs Mary H. Bruin

(Address) 2424 St. Charles st

15 Filed ....., 19..... C. HAMPSON JONES, M. D. Registrar

G 32 - 1929 Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Colocolar

Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Mooney M. D.

8/2 1929 (Coroner) (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loudon Park Cemetery Aug 3 1929

20 UNDERTAKER — ADDRESS

Chas. G. Black 742 W. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Gary 2100 W Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48156

CERTIFICATE OF DEATH

161-002 E 48156

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2722 Harford Ave ST., WARD)

2—FULL NAME Harry Lehmann

(a) RESIDENCE NO. 2722 Harford Ave ST., 4-46 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2. 1929

7 AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Max Lehmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Gasta

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Max Lehmann
(Address) 2722 Harford Ave

15 8-3 1929 C. HAMPSON JONES M. D. Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2. 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/1/29, 19, to 8/2/29, 19, that I last saw h alive on 8/2/29, 19, and that death occurred, on the date stated above, at 2:40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cause

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 8/1/29

Was there an autopsy? by

What test confirmed diagnosis?

(Signed) Benjamin Terry, M. D.

8/3/1929 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden

DATE OF BURIAL: 8/5 1929

20 UNDERTAKER: H. H. Cook

ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48157

CERTIFICATE OF DEATH

129

E 48157

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1806 E. Madison St. WARD)

2—FULL NAME Annie Brandt

(a) RESIDENCE NO. 1806 E. Madison St. WARD 12

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of: James Brandt

6 DATE OF BIRTH (month, day, and year): Oct. 5 1884

7 AGE: Years 45 | Months 5 | Days 24 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General natore of indostry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Annie Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: James Brandt

(Address): 1806 E. Madison

15 Filed 3 1929, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1929

17 I HEREBY CERTIFY, That I attended deceased from March, 1929, to Aug 1, 1929, that I last saw h[illegible] alive on July 31 1929 and that death occurred, on the date stated above, at 12 02 a/pm m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulonephritis Nephritis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Uremia, Renal Insufficiency

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. T. Gahring, M. D.

Aug 2 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natore of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashley County — DATE OF BURIAL: Aug 3 1929

20 UNDERTAKER: Mrs. R. G. Elbert — ADDRESS: 1725 Ashland

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48158

CERTIFICATE OF DEATH

45

E 48158

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 179 N Linwood ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles L Thompson

(a) RESIDENCE NO. 179 N Linwood ST., 6-11 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie L Thompson

6 DATE OF BIRTH (month, day, and year) Aug 25 65

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 130

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Dept City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER William Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Mollie L Thompson

(Address) 179 N Linwood

15 Filed 8-3 1929 Dat C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Aug 2, 1929, that I last saw h alive on Aug 1, 1929 and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis Caused

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 20. 28.

Was there an autopsy? no

What test confirmed diagnosis? Operation & Laboratory findings

(Signed) Wm B Lippman M. D.

8/2, 19 29 (Address) 718 W Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Aug 5 1929
20 UNDERTAKER W M Routson	ADDRESS 223 N Smith

IMPORTANT.—SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48159

CERTIFICATE OF DEATH.

48159

x129 E 48159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Wernly

(a) RESIDENCE NO. Ellicott city ST. 14-20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred unk. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Cal	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 040

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harfield Beach (Address)

15 Filed G 3 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-2-1929

17

I HEREBY CERTIFY, That I attended deceased from 8-1-, 19 29. to 8-2-, 19 29.

that I last saw h~ alive on 8-2-, 19 29.

and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-renal

Uraemia & Coma

Gangrene left leg.

Contributory unknown duration yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Harrison, M. D.

8/3. 1929 (Address) Woodlawn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem DATE OF BURIAL Aug 5, 19 29

20 UNDERTAKER Easton Bros ADDRESS Ellicott City

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

297672 E. 48160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x84 E 48160

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2—FULL NAME Lottie McInnes

(a) RESIDENCE NO. Fayetteville- ST., N-Car WARD 7-9

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/24/09

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Car

PARENTS

10 NAME OF FATHER Chas. McInnis

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Car.

12 MAIDEN NAME OF MOTHER Flora Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed Aug 5 1929 C. HARRISON JONES, M. D. Registrar

G. - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 - 29

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Aug 5, 1929, that I last saw her alive on Aug 3, 1929, and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - Benign

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E. H. Campbell Jr. M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fayetteville N C.

DATE OF BURIAL: 8/3/29

20 UNDERTAKER: Joseph Ahern

ADDRESS: 221 Bway

Spec.—1-12-23—M&T—500 Blks.

E 48161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 48161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 Westwood ave ST., WARD)

2-FULL NAME Myrtle L. Duvall

(a) RESIDENCE NO. 1632 Westwood ave ST. 15-21 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Duvall

6 DATE OF BIRTH (month, day, and year) 12-26-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury, Md.

PARENTS

10 NAME OF FATHER George Dutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Milburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph Duvall

(Address) 1632 Westwood ave

15 Filed AUG 4 1927

G. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3- 1927

17

I HEREBY CERTIFY, That I attended deceased from 7-13- , 1927, to 8-3- , 1927, that I last saw h[illegible]live on 8-3- , 1927, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

History

Personal Knowledge (duration) yrs. 1 mos 3 wks

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

, 19 (Address) 1816 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salisbury Md	Aug 5 1927

20 UNDERTAKER Robert E. Williams ADDRESS 1515 W. Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 48162

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ralph Weiss

(a) RESIDENCE NO. 1323 Forsuch Ave ST. 9-46 WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Weiss

6 DATE OF BIRTH (month, day, and year): Dec. 4. 1906

7 AGE — Years: 22 | Months: 7 | Days: 29 | If LESS than 1 day, ...hrs. or ....min.: 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Press Helper

(b) General nature of Industry, business, or establishment in which employed (or employer): 056

(c) Name of employer: Balt Sun

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles B. Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Edith Reiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Charles L Weiss

(Address) 1323 Forsuch Ave

15 Filed ....., 19 .....

AUG 4 - 1929

HANSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 3-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 29, to Aug 3, 19 29, that I last saw h.im alive on Aug 3, 19 29 and that death occurred, on the date stated above, at 2 PM m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation

(duration) yrs. mos. 4 hrs

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? by clinical

(Signed) H B Lundy M. D.

19 (Address) 1323 Forsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 8/3 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 127 E Saratoga St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48163

CERTIFICATE OF DEATH

49 E 48163

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Bolton ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. John Homer Hoffman

(a) RESIDENCE NO. 1809 Bolton ST. 14-20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 16 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise L. Burke Hoffman

6 DATE OF BIRTH (month, day, and year) Aug. 17, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	11	15 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Dr. David P. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Maria L. Hilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Louise L. B. Hoffman

(Address) 1809 Bolton St.

AUG 4 - 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1929

17 I HEREBY CERTIFY, That I attended deceased from May, 1927, to Aug 2, 1929, that I last saw h. alive on Aug 2, 1929, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder and metastases

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sight. (Cystoscopic)

(Signed) J. Chesebrough, M. D.

. 19 (Address) 1800 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Aug 5 1929
20 UNDERTAKER Wm. Tuckner & Son	ADDRESS North Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48164

CERTIFICATE OF DEATH

31 E 48164

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Doris E. Perry

(a) RESIDENCE NO. 2834 Washington Blvd ST. 25-72 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert L. Perry

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0-37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Noratel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Drive

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed AUG 4 - 1929, 19 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1929, to August 2, 1929, that I last saw her alive on August 2, 1929 and that death occurred, on the date stated above, at 1.35 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Jas Stroud, M. D.

8-2, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Augs 1929
20 UNDERTAKER W. G. Pickneys Sons	ADDRESS Pimlico Natl

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 48165 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 48165

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helene D. Gray

(a) RESIDENCE NO. 228 S. Collington Ave Ward 1-3

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 1928

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William M. Gray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Helene Danielak

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Helene Gray

(Address) 228 S. Collington Ave

15 Filed AUG 4 - 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

Aug 3/29 (Signed) G. E. Radcliffe M. D.

, 19 (Coroner) (Address) 143 N Rose

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In [illegible] yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Date of Burial Aug 5 1929

20 UNDERTAKER ADDRESS John H Wilder 1012 Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48166 ✓ 31 E 48166

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Eastern ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Magdalena M. Palasik

(a) RESIDENCE NO. 2104 Eastern ave ST., 1-3 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Palasik

6 DATE OF BIRTH (month, day, and year) July 17-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Skalecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes Galazka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Palasik

(Address) 2104 Eastern ave

15 Filed AUG 4 - 1929 Registrar HARRY JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1-1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to Aug. 1, 1929

that I last saw her alive on Aug. 1, 1929

and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Chronic (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & clinical findings

(Signed) Thos. Cummins M. D.

Aug. 1 1929 (Address) 2310 Eastern Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL 8 1929

ADDRESS

20 UNDERTAKER John N. Weber 1014 Chester

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-002

E 48167 REGISTERED NO. E 48167

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 N. Glover ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. Auld Jr.

(a) RESIDENCE NO. 613 N. Glover ST., 6-10 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 27/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John F. Auld Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lillie Wesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: John F. Auld Sr.

(Address): 613 N. Glover st

15 Filed ... 1929 Hilton Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 2/29

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to Aug 2, 1929 that I last saw h alive on Aug 2 1929 and that death occurred, on the date stated above, at 12 55 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 7 ds.

Contributory Myocarditis

(Secondary) Tuberculosis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John B Lemmon M. D.

8/3, 1929 (Address) 718 N Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Aug 5 1929
20 UNDERTAKER: Philip Herwig	ADDRESS: 2016 Orleans

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 48168

E 48168

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 26 WARD) 26-37

2—FULL NAME Baby Boyce

(a) RESIDENCE NO. Baltimore City Hospitals ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	--

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) July 31, 1929

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or 25 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work --

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Alfred Boyce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Rachel Messick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 4 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 19 29, to July 31, 19 29, that I last saw her alive on July 31, 19 29 and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Premature - 6 mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? --

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas. E. Arnold, M. D.

7-31 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Methodist Prot. Cem. Baltimore Md.

DATE OF BURIAL aug 5th 1929

20 UNDERTAKER Lilly & Miller Inc.

ADDRESS 400 S. Wolfe St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48169

CERTIFICATE OF DEATH

37-001 E 48169

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals (26) ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachel A. Boyce

(a) RESIDENCE NO. 628 S. Newkirk ST., 26 WARD 26-37

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Boyce

6 DATE OF BIRTH (month, day, and year) June 26 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19 yrs.	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John R. Messick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel Messick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Alfred Boyce

(Address) 628 S. Newkirk st.

15 Filed AUG 4 1929, 19 WILLIAM H. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Aug 4, 1929

that I last saw h e Y alive on Aug 4, 1929

and that death occurred, on the date stated above, at 5 40 a. m.

The CAUSE OF DEATH* was as follows: Miliary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis unknown ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas Arnold K. M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Methodist Prot. Cem. at Dundalk	Aug. 5th 1929
20 UNDERTAKER Lilly & Zeller Inc.	ADDRESS 403 S. Hoyt St

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 48170

E 48170

CERTIFICATE OF DEATH. 44

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St., WARD)

2-FULL NAME Samuel G. Rabinowich

(a) RESIDENCE NO. 2418 Lakeview Ave St. 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widow(er), or Divorced, (write the word)
Male	White	Married

5a If married, widow(er), or divorced
HUSBAND of (or) ~~WIFE of~~ Lena H. Rabinowich

6 DATE OF BIRTH (month, day, and year) Dec 23-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
55	55	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant James A. Rabinowich
(Address) 2418 Lakeview.

15 Filed 4 - 1929, 19 C. HARRISON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1929

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to Aug 3, 1929.

That I last saw h/~~s~~ alive on Aug 3, 1929,

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus. → metastases to lungs and pleura → dyspnoea with effusion → respiratory failure & Cardiac (duration) Known since yrs 7 mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laryngoscopic Exam. & Oesophagoscopic

8/3, 1929 (Signed) B. J. Cohen, M. D.
(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mosh Rood — DATE OF BURIAL 8/4 1929

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 48171

1-PLACE OF DEATH 612 N. Lakewood Ave.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., ... WARD)

2-FULL NAME Stephen Cadden

(a) RESIDENCE NO. 612 N. Lakewood Ave ST. WARD 7-10

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/31/79

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
—	—	—	9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md!

PARENTS

10 NAME OF FATHER Aloysius Cadden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catherine M. Mannion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Aloysius Cadden
(Address) 1427 Darley Ave

15 Filed 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/2/29, 19 ... to ... 19 ...

that I last saw h alive on ... 19 ...

and that death occurred, on the date stated above, at 12 20 P m

The CAUSE OF DEATH* was as follows:

Asphyxia Livida
pneumonia both

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. Sobilad M. D.

19 8/4 1929 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. A.A.	8/5 1929
20 UNDERTAKER	ADDRESS
Margaret L. Flynn	1422 Light St.

CAUSE OF DEATH to be plainly written, so that it may be properly classified. EXACT NATURE OF OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48172

1—PLACE OF DEATH

CERTIFICATE OF DEATH

89 E 48172

REGISTERED NO.

CITY OF BALTIMORE: (No. 2712 N. Calvert St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Early

(a) RESIDENCE NO. 2712 N. Calvert St. ST., 17.50 WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Tregellas

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ass't Treasurer

(b) General nature of industry, business, or establishment in which employed (or employer) United Railways

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Early

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William Early

(Address) 2710 N. Calvert St.

15 Filed AUG 4 - 1929 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2-29

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug. 2, 1929, that I last saw him alive on Aug 1, 1929 and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick L. Green, M. D.

, 19 (Address) 2827 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug. 5, 1929
20 UNDERTAKER John O. Mitchell & Sons	ADDRESS 1900 Eutaw Pl.

Mahlon B Mitchell

Spec.—2-29-28—L. F. S.—500 Bks.

E 48173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 90 E 48173

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 Park ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Dodson

(a) RESIDENCE NO. 614 Park Ave ST., 11-25 WARD 4 Mitchells Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mch 21. 1852

7 AGE — Years: 77 — Months: 4 — Days: 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Island Md.

PARENTS

10 NAME OF FATHER: Samuel J. Skinner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lucy D. Davis

(Address) 614 Park ave

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D. Registrar

8 4 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 3. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30 . 1929 . to Aug 3rd . 1929 .

that I last saw h[illegible] alive on Aug 3rd . 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic hypostatic with hypostatic

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) [illegible] . M. D.

8/4 . 1929 (Address) 1111 Mary[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Michaels Md — DATE OF BURIAL: Aug 5 1929

20 UNDERTAKER: John C. Mitchell Sons — ADDRESS: 1320 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

Lida Barcus

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48174

CERTIFICATE OF DEATH

74-001

E 48174

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1717 W. Fayette St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lida Barcus

(a) RESIDENCE NO. 1717 W. Fayette St. ST., 19-27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co., Md.

PARENTS

10 NAME OF FATHER William Barcus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co., Md.

12 MAIDEN NAME OF MOTHER Eliza Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co. Md.

14 Informant Mrs. W. Nichols

(Address) 1717 W. Fayette St.

15 Filed AUG 3 1929 19 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to Aug. 2, 1929, that I last saw h... alive on Aug. 2, 1929 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. McCoolahan, M. D.

8/3 19 29 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Queenstown Md	Aug 5 19 29
20 UNDERTAKER Horace F. Burgee	ADDRESS Liberty Road

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48175

CERTIFICATE OF DEATH

129 E 48175

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2136 N Fulton ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A Garner

(a) RESIDENCE NO. 2136 N Fulton ST., 15, 59 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	N	M.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie B Garner

6 DATE OF BIRTH (month, day, and year) June 20 67

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER C. Oliver Garner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Babylon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Carrie B Garner

(Address) 2136 N Fulton

15 Filed ... 19 ... C. HERMAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 29

17 I HEREBY CERTIFY, That I attended deceased from 7/27, 19 29, to 8-3, 1929, that I last saw h[illegible] alive on 8-1, 1929 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. H. Jones, M. D.

8/4, 1929 (Address) 1722 Eutaw Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 5 1929
20 UNDERTAKER	ADDRESS
J M Routson	2238 N Fulton Ave

Cor.—10-10-29—A Co.—100 Bks.

E 48176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 E 48176

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mutlin Ave St., Ward)

2-FULL NAME Benj F. Maloney

(a) RESIDENCE NO. 35 S. Stricker St., 19-26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy C. Maloney

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	—	—	—

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Wks
(c) Name of employer

9 BIRTHPLACE (city or town) New Market
(State or country) Va

PARENTS

10 NAME OF FATHER Jno A. Maloney

11 BIRTHPLACE OF FATHER (city or town) New Market
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) New Market
(State or country) Va

14 Informant Carroll R Maloney
(Address) New Market Va

15 Filed 4-1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Shock Traumatic secondary to Long Struck & (duration) yrs. mos. da.

18 Where did disease contracted Hit by automobile

*Did above person have a fracture of? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Frame M. D.

8/4. 1929 (Address) 2959 W Eldorado

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Market Va	Aug 7 1929

20 UNDERTAKER	ADDRESS
John C Miller	2472 E Oliver St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Marti

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48177

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., Ward)

2-FULL NAME Ignacio Marti

(a) RESIDENCE NO. 722 S-Bway St., 2-4 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

197 E 48177

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896 Autopsy

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Inn-Keeper
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Spain

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant J. Sagardia
(Address) 716 S. Broadway

15 Filed AUG 4 - 1929 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 2- 1929

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Homicide
Gun Shot Wound Abdomen and Revolver (duration) yrs. mos. 7 da.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 1 da.

18 Where was disease contracted — If not at place of death? —
Did an operation precede death? Yes Date of July 31/29
Was there an autopsy? Yes
What confirmed diagnosis? Autopsy
(Signed) [illegible] M. D.
, 19 (Address) 173 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	8/6 1929
20 UNDERTAKER E. J. Fanning Inc	ADDRESS 1938 E Lafayette

Spec.—2-29-28—L. F. S.—500 Blks.

227782

E 48178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 84 Bltz-Aut

REGISTERED NO. E 48178

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Fossett -

(a) RESIDENCE NO. 1105 Harden St. ST., WARD Silver Spring Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 8/31/76

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	11	3 4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transportation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER George W. Fossett

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va -

12 MAIDEN NAME OF MOTHER Emma Grout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Reads -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 4 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 - 29

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 , 1929, to Aug 4 , 1929, that I last saw h.. alive on Aug 4 1929 and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Bronzi (Glioma)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? yes -

What test confirmed diagnosis? Operation

(Signed) E. H. Campbell Jr. , M. D.

, 19 (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mayer Family W Va	Aug 6 1929
20 UNDERTAKER Fess & Dailey Brunswick	ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48179 (1929) E 48179

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 658 W. Fairmount Ave Ward) 4 25

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wesley Aultow

(a) RESIDENCE NO. 658 W. Fairmount Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General naturo of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Alberta Thorton
(Address) 926 N. Gilmor St

15 Filed 8-5-1929 G. HERBERT JONES, M. D. Registrar
per [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Heat Stroke

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

8/4 . 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen	Aug. 5 1929
20 UNDERTAKER	ADDRESS
Frank W. Chase & Son	[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48180

CERTIFICATE OF DEATH

90 E 48180

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Mary Udes

(a) RESIDENCE NO. 3112 Virginia Ave. ST., 27-52 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Udes

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Charles ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address): Balto. City Hospitals

15 Filed ..... 19..... Registrar

AUG 3 - 1929

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 1, 19 29 to August 2, 19 29.

that I last saw h.. alive on August 2, 1929

and that death occurred, on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute, c
Insufficiency & auricular fibrillation

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C.C.

(Signed) Marvin M. McLean, M. D.

8-2, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	8/5 1929
20 UNDERTAKER	ADDRESS
Chas. B. Kuchanskas	637 S. Paca St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48181

CERTIFICATE OF DEATH

60-002 ✓

E 48181

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Frdenik Dreyer

(a) RESIDENCE NO. 1579 Sycamore ST., 25-77 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	63		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 62

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Dreyes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Neuhauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/29

17

I HEREBY CERTIFY, That I attended deceased from 7/12, 1929, to 8/4, 1929

that I last saw him alive on 8/4, 1929

and that death occurred, on the date stated above, at 12 51 P. m.

The CAUSE OF DEATH* was as follows:

Toxic septic thyroid

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/2/29

Was there an autopsy? No

What test confirmed diagnosis Clinical & Operation

(Signed) J Feyko, M. D.

8/4, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 6 1929
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	2073 Pen

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48182 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48182

CERTIFICATE OF DEATH 161-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 510 Edgewood Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant of Harry & Edna M, Fitzburger

(a) RESIDENCE NO. 510 Edgewood Ave ST. 20-70 AD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Harry Fitzburger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Edna M. Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Harry Fitzburger

(Address): 510 Edgewood Ave

15 Filed G. 19 G. LAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3/29

17

I HEREBY CERTIFY, That I attended deceased from 7/29 . 19 29 . to 8/2/29 . 19 29 .

that I last saw her alive on 8/2/29 19

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Edmunds, M. D.

. 19 (Address) 1340 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 8/3 1929

20 UNDERTAKER: I. Few McCully

ADDRESS: 130 E. Fort

Spec.—2-29-28—L. F. S.—500 Bks.

E 48183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 48183

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Southern Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank T. Rommel

(a) RESIDENCE NO. 1320 Central Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
male	white	married

If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE~~ of Mary R. Rommel

6 DATE OF BIRTH (month, day, and year) Nov 18th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Nicklson Rommel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Elizabeth Talmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mary R Rommel

(Address) 1320 Central Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1st, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1928 to Aug 1 1929

that I last saw h alive on Aug 1 1929

and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic

(duration) yrs. 9 mos. 13 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. 13 ds.

18 Where was disease contracted if not at place of death? ~~No~~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Wm F Malone M. D.

Aug 3, 1929 (Address) Bowdoin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 5 1929
20 UNDERTAKER	ADDRESS
Robt T. Turner	1442 N Broadway

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48184

CERTIFICATE OF DEATH.

161-001 E 48184

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave ST., WARD)

2-FULL NAME Baby girl Cartwright

(a) RESIDENCE NO. 1609 Eutaw Place ST., 14-20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-3-29

7 AGE	Years	Months	Days	If LESS than 1 day 2½ hrs or ....min.
~~1 day~~				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Carl Cartwright

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Wesson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wesson

14 Informant Carl Cartwright
(Address) 1609 Eutaw Place

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-3 .1929. to 8-3 .1929.

that I last saw her alive on 8-3 .1929.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) Aug

19 PLACE OF BURIAL, CREMATION OR REMOVAL Maund Olivet Cem

DATE OF BURIAL ~~JUNE~~ Aug 5 1929

20 UNDERTAKER Mrs - Mrs A S Finch

ADDRESS 2572 Wilkins Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

48185

CERTIFICATE OF DEATH.

118-001 E 48185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST., WARD) 15-21

2-FULL NAME Cole Craig

(a) RESIDENCE NO. 1650 Fulmore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Saint Casthon

PARENTS

10 NAME OF FATHER Willie Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unk

14 Informant John Moore

(Address) 1650 Fulmore St

15 Filed ..... 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 1929, to Aug 4 1929, that I last saw h alive on Aug 4 1929, and that death occurred, on the date stated above, at 9.35 a. m.

The CAUSE OF DEATH* was as follows:

Shock Fractured Inguinal Hernia Gangrene & Peritonitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard Sarn, M. D.

8/4, 1929 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurence S. Carolina	Aug 5 1929
UNDERTAKER	ADDRESS
Virginia G Brooks	1463 N. Carey

HAROLD JONES, M. D.

AUG 5 1929

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48186

CERTIFICATE OF DEATH

40 E 48186

REGISTERED NO.

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Julia Fall

(a) RESIDENCE NO. 1605 Fait Lane ST., 8-12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	42 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Fall ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Wright ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed AUG 5 - 1929 H. Robert Young Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-16-29, 19..., to 8-2, 19 29

that I last saw h[illegible] alive on 8-2, 19 29

and that death occurred, on the date stated above, at 10:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Focal

(duration) over 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) over 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.C.: Clin. Lab.

(Signed) Harwin W. McLean, M. D.

BALTIMORE CITY HOSPITALS

8-2, 19 29 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mashtang cemetery	aug 6 1929
20 UNDERTAKER Edward Bryan	ADDRESS 651 orleans st

Spec.—1-12-23—M&T—500 Bks.

E 48187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 48187

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 Somerset ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilly Crockett

(a) RESIDENCE No. 415 Somerset ST. 5 8 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domistic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) V. a

PARENTS

10 NAME OF FATHER Readmen Vennie

11 BIRTHPLACE OF FATHER (city or town) (State or country) V. a

12 MAIDEN NAME OF MOTHER Mellie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) V. a

14

Informant James Crockett

(Address) 415 Somerset st

15

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1929

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to Aug 2, 1929, that I last saw h[illegible] alive on Aug 2, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Acute myocarditis, Uremia

(duration) yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) W. L. Perry, M. D

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: aug 6 1929

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EARLY REGISTRATION OF DEATH IS very important. See instructions on back of certificates.

8-5-1929 HAMPSTONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48188

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109-002 E 48188

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2561 W. Lombard St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta Schmeck

(a) RESIDENCE NO. 2561 W. Lombard St WARD 20-69

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 6 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Martin F. Schmeck

6 DATE OF BIRTH (month, day, and year): June 8th 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Wils Wm Sahlen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Estelle Clift

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wils Wm Sahlen

(Address) 2561 W. Lombard St

15 Filed Aug 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2nd 29

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to Aug 2, 1929

that I last saw her alive on Aug 2, 1929

and that death occurred, on the date stated above, at 10:32 A m.

The CAUSE OF DEATH* was as follows:

Septic sore throat & acute arthritis

(duration) yrs. 5 wks. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute endocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Harry Weibel M. D.

8/3, 1929 (Address) 1224-1226 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 5th 1929
20 UNDERTAKER	ADDRESS
H. S. Kuhlpert	850 W. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48189

CERTIFICATE OF DEATH

91-002 E 48189

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 E. Preston ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary V. McGuire

(a) RESIDENCE NO. 913 E Preston ST. 10-14 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth, yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced (or) WIFE of Bernard J. McGuire.

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Md.

PARENTS

10 NAME OF FATHER James Barron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Lamb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Catherine McGuire

(Address) 913 E Preston St

15 Filed AUG 5 1929, 19 HAMILTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to August 3, 1929, that I last saw h[illegible] alive on August 3rd, 1929 and that death occurred, on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual symptoms

(Signed) Mary F Leyburn M. D.

8-7, 1929 (Address) 118 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 7 1929
20 UNDERTAKER	ADDRESS
Henry Hoen Sons Inc.	1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Aug 4-1929

E 48190

CERTIFICATE OF DEATH

44

E 48190

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1575 Eastern ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maryanna Dudek

(a) RESIDENCE NO. 1575 Eastern ave ST., 3-4 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1849.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Joseph Wrzesiny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Wojciech Dudek

(Address) 1575 Eastern ave

15 AUG 5 - 1929 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1929.

17 I HEREBY CERTIFY, That I attended deceased from August 3 1929 to Aug. 4 1929.

that I last saw her alive on Aug. 4 1929

and that death occurred, on the date stated above, at 9.20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

2 Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

8/5 1929 (Address) 1579 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 6 1929.
20 UNDERTAKER	ADDRESS
George A Weber	705 S. Ann st

Spec.—2-29-28—L. F. S.—500 Blks.

E 48191

HEALTH DEPARTMENT—CITY OF BALTIMORE

X135

E 48191

CERTIFICATE OF DEATH

1—PLACE OF DEATH Catholic House of
CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Msgr. John T. McElroy

(a) RESIDENCE NO. 136 Ellis ST. 9-17 WARD
(Usual place of abode) Elsewhere in U.S.
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/6/1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Priest
(b) General nature of industry, business, or establishment in which employed (or employer) 065
(c) Name of employer

9 BIRTHPLACE (city or town) Bath Me
(State or country)

PARENTS

10 NAME OF FATHER Bernard J. McElroy

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Ann C. Harting

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Rev. James McElroy
(Address) 1403 N. Washington St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-2-1929.

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 1929, to 8-2, 1929.
that I last saw him alive on 8-2, 1929
and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows

Hypertrophied prostate

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-29-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical test.

(Signed) W Blue Driy, M. D.
St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 8/6/29

20 UNDERTAKER George J. Ruth & Co — ADDRESS 1735 Harford

G.S. 1029 HAMILTON JONES N.Y.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48192

CERTIFICATE OF DEATH

88

E 48192

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1430 Hanover Court ST., WARD)

2—FULL NAME Sarah Jenkins.

(a) RESIDENCE NO. 1853 N. Spring St. WARD 9-18

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilfred Jenkins

6 DATE OF BIRTH (month, day, and year) 7/1/1875

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
54	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 07

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mary Jenkins

(Address) 1853 N. Spring St.

15 Filed AUG 5 - 1929, 19 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 29

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to Aug 2, 1929, that I last saw h alive on Aug 1, 1929 and that death occurred, on the date stated above, at 3:20A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis, Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Wm. L. Hamberger M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL 8/5/29

20 UNDERTAKER George J. Ruth — ADDRESS 1205 Harford

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48193

CERTIFICATE OF DEATH

31 E 48193

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3722 Hudson ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Zaporowski,

(a) RESIDENCE NO. 3722 Hudson ST., 26-37 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22yrs. 7 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31-1907.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
21	22	7	4 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory hand.

(b) General nature of industry, business, or establishment in which employed (or employer) 0 86

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) MD.

PARENTS

10 NAME OF FATHER Henry Zaporowski,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Stephana Rudzinski,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland,

14 Informant Mrs. Stephans Zaporowski, (Mother)
(Address) 3722 Hudson Street

15 Filed ....., 19 .....
5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1929, to Aug. 4, 1929, that I last saw h[illegible] alive on Aug 3rd. 1929 and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. 24 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X ray & sputum exam.

(Signed) Peter C. Stabilito, M. D.

, 19 (Address) 104 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Aug. 7 1929.
20 UNDERTAKER	ADDRESS
M. F. Sadowski,	2215 Pulham Ave

Cor.—10-10-29—A Co.—100 Bks.

48194

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dudonis

CERTIFICATE OF DEATH

113 E 48194

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hospital Ward)

2-FULL NAME Dorothy L Dudonis

(a) RESIDENCE NO. 612 Gough St. 3-+ Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 21-1928

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm Dudonis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ernestine Dudonis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Wm Dudonis
(Address) 612 Gough St.

15 Filed ..... 19.. AUG 1 - 1929 H. FINNEGAN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro. Enteritis

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 1 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

What was autopsy? —

What test confirmed diagnosis? Clinical Tests

(Signed) Wm C Bladel M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 8/5 1929

UNDERTAKER Wm Fiaskowski ADDRESS 1015 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48195

CERTIFICATE OF DEATH

90 E 48195

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George L. Miller

(a) RESIDENCE NO. 763 W. Lexington ST., 4-25 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Miller ?

6 DATE OF BIRTH (month, day, and year) April 29, 1862 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67 ?	3	5	4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? 10 04

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Germany Md.

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Germany

12 MAIDEN NAME OF MOTHER Kate ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Germany

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed Aug 6 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-14, 1929, to 8-3, 1929, that I last saw him alive on 8-3, 1929 and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Toxemia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic bronchitis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C.E.

(Signed) Marvin M. McClean, M. D.

8-4, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug. 6 1929

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 West Baltimore St

Spec.—1-12-23—MAT—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48196

CERTIFICATE OF DEATH 100-001

E 48196

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balt. Gen'l Hosp. WARD)

2-FULL NAME Mrs. Mary E Hoffman

(a) RESIDENCE NO. 2616 W Fayette ST. WARD 20-69

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Thomas Hoffman

6 DATE OF BIRTH (month, day, and year) November 11, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	30	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ely B. Pecroft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie E. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. Jacob T. Hoffman (Address) 2616 W. Fayette Street

15 Filed 19 by Registrar

8-5-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1929 to Aug 3 1929 that I last saw her alive on Aug. 3, 1929 and that death occurred, on the date stated above, at 11 50 A.M.

The CAUSE OF DEATH* was as follows:

Lung Abscess

(duration) 8 yrs mos ds.

CONTRIBUTORY (Secondary) Massive Collapse of Lung (duration) yrs mos ds.

(a) Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 8-1-29

Was there an autopsy? Yes. Operation + Autopsy

What test confirmed diagnosis?

(Signed) H. Goldspink M. D.

8/31. 1929 (Address) West Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug. 6 1929

20 UNDERTAKER J. Wm. Cook ADDRESS 1003 West Baltimore St

C. HARRISON JONES, M. D.

(See instructions on back of certificates. IT IS very important)

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48197

CERTIFICATE OF DEATH

90 E 48197

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2913 St. Paul ST., WARD)

2—FULL NAME Marie Elizabeth Wagner

(a) RESIDENCE NO. 2913 St. Paul ST., 12-50 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 26" 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	7	6.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George William Wagner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea M. Tegler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant George L. Wagner
(Address) 2913 St. Paul St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August, 2nd. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1928, to aug 2, 1929, that I last saw her alive on aug 2, 1929, and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis Insufficiency, (Auricular - fibrillation)

(duration) yrs. 10+ mos. ds.

CONTRIBUTORY (Secondary) Renal Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) G Carroll Lockard M. D.

8/3, 1929 (Address) 4 East Preston Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug. 5" 1929
20 UNDERTAKER Jacob B Cook	ADDRESS 1003 N Calv

IMPORTANT: See instructions on the back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48198

CERTIFICATE OF DEATH

118-002

E 48198

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. Ward)

2-FULL NAME Reverd Simms

(a) RESIDENCE NO. 1002 Mosher St. 16 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David

6 DATE OF BIRTH (month, day, and year): ? 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: Moses Bailey

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Cordelia Swan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Unknown

14 Informant: Lena Bell
(Address): 1302 Laurens St.

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug — 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secundary) Carcinoma

(duration) yrs. mos. — ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 1736 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	8-5- 1929
20 UNDERTAKER	ADDRESS
Mrs. Geo. H. Holland	1631 Druid Hill Ave

Spec.—1-12-23—M&T—500 Bks.

E 48199 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital WARD)

2-FULL NAME Augustus Manns

(a) RESIDENCE NO. 119 Preston ST., 11-24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82(?)	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coachman 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Agustus Manns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Niece

(Address)

15 Filed 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Aug 2, 1929, that I last saw h[illegible] alive on Aug 2, 1929, and that death occurred, on the date stated above, at 1557 m.

The CAUSE OF DEATH* was as follows: Cardiac Decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. McDonald M. D.

. 19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calavery

DATE OF BURIAL 8-5 1929

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Old Hill Av

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48200 1/2

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48200 1/2

CERTIFICATE OF DEATH

161-001 E 48200

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 76th Lemmon Ave ST., WARD)

2—FULL NAME None - Inf. O'Neil

(a) RESIDENCE NO. 76th Lemmon Ave ST., 16 67 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
?	W -	Infant -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 1 - 1929 -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None -

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) above address -
(State or country)

PARENTS

10 NAME OF FATHER Thomas J. O'Neil

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md -

12 MAIDEN NAME OF MOTHER Marie Lotter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md -

14 Informant D. Hayes my. Md -
(Address) 311 St Paul Place.

15 Filed AUG 5 - 1929 19 CAMPBELL JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2/29 -

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature infant - Precipitate delivery. Lived about 1 minute according to statement of parents - Was seen by me several hours later -

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

..... (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. Hayes - , M. D.

, 19 (Address) 311 St Paul Pl -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] HOSPITAL	19
20 UNDERTAKER	ADDRESS

AUG 3 - 1929

important. See instructions on back of certificates.

Spec.—1-15-23—M&T—500 Bks.

E 48201 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 113 E 48201

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospt. St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer J Reid

(a) RESIDENCE NO.: 2067 N Gilmore St. 19-27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

6 DATE OF BIRTH (month, day, and year) Oct 7, 1928

7 AGE	Years	Months 9	Days 26.	LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Emmer Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md.

12 MAIDEN NAME OF MOTHER Catherine Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. County Md.

14 Informant Mother (Address)

15 Filed 5-1929 19 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1929

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to Aug 3, 1929.

that I last saw h[illegible] alive on Aug 30, 1929.

and that death occurred, on the date stated above, at 4 20 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(duration) about yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George McDonald D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 5, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 32 [illegible] Schroeder Sr

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48202

CERTIFICATE OF DEATH.

REGISTERED NO. E 48202

1-PLACE OF DEATH

City of BALTIMORE: (No. Either Co Road & Maryland Ave. St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Eden

(a) RESIDENCE NO. 1824 Ashland Ave St. 7-13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60.	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Robert Eden

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Mary E. Riley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Wm Riley

(Address) 1824 Ashland Ave

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2. 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

Aug 5. (Signed) W. J. Riley (Coroner) M. D.

1, 1929 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Parkwood Cem. Aug. 5 1929

20 UNDERTAKER — ADDRESS

Wm. C. Miller & Son 2304 Frey St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48203

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3612 Greenmount Ave ST., WARD)

2—FULL NAME George P. Smith.

(a) RESIDENCE NO. 3612 Greenmount Ave ST., 12-49 WARD
(Usual place of abode) Lic
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 3, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired, Ord

(b) General nature of industry, business, or establishment in which employed (or employer) Credit Man

(c) Name of employer Lowney Bauer.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John C Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Adams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Wm F Smith
(Address) 4204 Roland Ave

15 Filed AUG 5 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug 3, 1929, that I last saw him alive on Aug 2, 1929 and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senility

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas L Jones, M. D.

8/3, 1929 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	1929
20 UNDERTAKER George P Smith	ADDRESS 1315 Collins

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48204

CERTIFICATE OF DEATH.

129 E 48204

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 E. Madison ST., WARD)

2-FULL NAME EUGENIA H. KRUG

(a) RESIDENCE NO. 2405 E. Madison ST., 7-12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Krug Jr.

6 DATE OF BIRTH (month, day, and year) July 14, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	0	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob Herzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Heffner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Henry J. Krug (Son)

(Address) 2812 E. Chase St.

15 Filed 5 - 1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 . 1929 . to Aug 3 . 1929.

that I last saw h w alive on Aug 3 . 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs mos 3 d

CONTRIBUTORY (Secondary) Arterio Sclerosis Chronic Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed Alma B Leonard M. D.

8/4 1929 (Address) 718 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug. 6. 1929

20 UNDERTAKER: Henry Sauder & Sons Inc. — ADDRESS: BALTIMORE ST. & BROADWAY.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 48205 — REGISTERED NO. E 48205

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 N Fulton Ave. WARD) 15-59

2—FULL NAME Elizabeth Thomas

(a) RESIDENCE NO. 2108 N. Fulton Ave. WARD 15

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 45 yrs. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Thomas

6 DATE OF BIRTH (month, day, and year): 2-20-1884

7 AGE — Years: 70 — Months: 5 — Days: 13. — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: John Beltz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Bertha Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: John Thomas. (Address) 2108 N Fulton Ave.

15 Filed ... 5 - 1929 ... 19 ... H. ... JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31st 29.

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to Aug 31st, 1929, that I last saw h[e] alive on August 31st, 1929 and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) one yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urinalysis & Clinical

(Signed) Wm J Kuehn M. D.

25, 1929 (Address) 1701 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery — DATE OF BURIAL: 8-6-29.

20 UNDERTAKER: Martin Fahey Sons — ADDRESS: 1823 W North Ave.

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—1-10-21—M&T—1500 Bks.

48206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 50 E 48206

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Edward H. Myers

(a) RESIDENCE No. 516 E St., Sparrows Point ST., 12-51 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Leona E. Myers

6 DATE OF BIRTH (month, day, and year) June 27, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Wrightsville, Pa.

PARENTS

10 NAME OF FATHER John Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kathryn Uptergraph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

AUG 3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2 19 29

17

I HEREBY CERTIFY, That I attended deceased from July 25 .19 29. to August 2 .19 29.

that I last saw him alive on August 2 .19 29.

and that death occurred, on the date stated above, at 10:05 P. m.

The CAUSE OF DEATH* was as follows:

Tumor of the posterior mediastinum

(duration) unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic gastritis

(duration) unknown yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ralph E Porter M. D.

8/3 19 29 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL 8/5 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Holbrook

CAUSE OF DEATH to be properly certified. Attention is called to the penalties on back of certificates.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48207

CERTIFICATE OF DEATH

X 129 ✓

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. E 48207

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Shedrick Milburn

(a) RESIDENCE NO. Catonsville Md. ST., 4-7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 1892

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Unknown

14 Informant Mercy Hospt Records

(Address)

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

8-5-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-29

17 I HEREBY CERTIFY, That I attended deceased from 7-22, 1929, to 7-31, 1929, that I last saw him alive on 7-31, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis & hypertension

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs mos. 1- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lyke. M. D.

7-31-29 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem.	Aug 5, 1929
20 UNDERTAKER Wm R. H. Elliott	ADDRESS 125 Ashland Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48208 — REGISTERED NO. E 48208

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 5719 Hinner Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paulina W. Gould

(a) RESIDENCE NO. 5719 Hinner Ave. WARD 27-55 Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Gould

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
about	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Hiderll Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ann Berling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant T. J. Conner

(Address) 5719 Hinner Ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4-29

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to Aug 4, 1929, that I last saw h[er] alive on Aug 3, 1929 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Epithelioma of forehead.

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J. Wells, M. D.

, 19 (Address) 527 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 8/5 1929

20 UNDERTAKER W. S. Cook

ADDRESS 1212 Paul

AG 3 - 1929 LAWSON JONES, M.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

76 E 48209

1—PLACE OF DEATH Baltimore City Hospl.

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore Md ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Lukach

(a) RESIDENCE NO. 6511 Fait Ave ST., 26-37 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: 45 about

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(h) General nature of industry, business, or establishment, in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed AUG 5 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3-29

17

I HEREBY CERTIFY, That I attended deceased from 3-20 , 19 29 , to 8-3 , 19 29 .

that I last saw h... alive on 8-3 , 19 29

and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

General Paralysis 2 yrs

Syphilis

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul Fleischner M. D.

8/6 , 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U. S. National

DATE OF BURIAL: 8/6 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 Orleans

Spec.—2-29-28—L. F. S.—500 Bks.

Roeth

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 48210 E 48210

CERTIFICATE OF DEATH

74-002

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3016 Ione Terrace ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Roeth

(a) RESIDENCE NO. 3016 Ione Terrace ST., 9-44 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 3 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced WIFE of George Roeth

6 DATE OF BIRTH (month, day, and year) April 11, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Roeth

(Address) 3016 Ione Terrace

15 Filed AUG - 1929 C. J. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 30, 19 29, to Aug 3, 19 29,

that I last saw h alive on Aug 3, 19 29

and that death occurred, on the date stated above, at 4:45 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Carolan, M. D.

, 19 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	19
20 UNDERTAKER	ADDRESS
Wm. Cook	St. Paul St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

112

E 48211

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 747 W. Franklin St., WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Booth

(a) RESIDENCE NO. 747 W. Franklin ST., 17-26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 37 | Months unk | Days unk | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): O&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Culver Co.

PARENTS

10 NAME OF FATHER: Eliza Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country): C. Co

12 MAIDEN NAME OF MOTHER: Julia Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): C. Co.

14 Informant: Eugene Booth

(Address): East Port Md.

15 Filed 5-1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4th 29.

17 I HEREBY CERTIFY, That I attended deceased from Aug 4th, 1929, to Aug 4th, 1929.

that I last saw him alive on Aug 4th, 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Acute Gastritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Improper Diet

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Test.

(Signed) J. T. Dugan M. D.

19 (Address) 522 W. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Hicks

DATE OF BURIAL: 8/1 1929

20 UNDERTAKER: Charles E. Hicks

ADDRESS: 1434 Mitchell St

Spec.—2-29-28—L. F. S.—500 Bks.

E 48212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48212

REGISTERED NO.

1—PLACE OF DEATH St Joseph's Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ____ ST., ____ WARD)

2—FULL NAME Andrew O'Donnell

(a) RESIDENCE NO. 407 E. 22nd St. ST., 12-19 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ____ mos. ____ ds. How long in U. S., If foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Clara Silling

6 DATE OF BIRTH (month, day, and year) May 13-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	67	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Andrew O'Donnell

(Address) 407 E 22nd St

15 Filed Aug 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3-1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to Aug 3, 1929.

That I last saw h~~im~~ alive on Aug 2, 1929

and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

(duration) 10 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) ____ yrs. ____ mos. 4 hrs.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. H. Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 6 1929
20 UNDERTAKER Mary Mc Wadsell	ADDRESS 501 E 22nd St

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48213 E 48213

CERTIFICATE OF DEATH. 161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1230 Wall ST., 24 (WARD) 24-33

2-FULL NAME Infant of Mr & Mrs Roman V Dorsey

(a) RESIDENCE NO. 1230 Wall ST., 24 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 5 / 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Roman V Dorsey

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary C Hoye

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mrs R. V Dorsey

(Address) 1230 Wall St

15 Filed Aug 6, 1929 C. HAMPSON JONES, M. D. Registrar

5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929 to Aug 5, 1929

that I last saw him alive on Aug 5, 1929

and that death occurred, on the date stated above, at 1-30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxiation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. H. Jones, M. D.

Aug 6 1929 (Address) 6404 Holabird Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int. Calvert. DATE OF BURIAL Aug 6 1929

20 UNDERTAKER Fred. A Williamson & Son ADDRESS 703 Hanover

CAUSE OF DEATH to be printed plainly, in ink. DATE OF BIRTH is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48214

CERTIFICATE OF DEATH

90 E 48214

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2602 Stratmore Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mable Marie Mack

(a) RESIDENCE NO. 2602 Stratmore Ave ST. 27-44 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: James B. Mack

6 DATE OF BIRTH (month, day, and year): Jan. 1, 1896

7 AGE — Years: 33 — Months: 7 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles A. Fulda

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Christina Fetch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mr. James B. Mack
(Address) 2602 Stratmore Ave.

15 Filed ... 19... Registrar

5-1929 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to Aug 5, 1929

that I last saw h[illegible] alive on Aug 2, 1929

and that death occurred on the date stated above, at 11 a. m.

The CAUSE OF DEATH was as follows:

Mitral Regurgitation
Thrombosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): acute Chronic Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 806 N. Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemy.	Aug 6, 1929
20 UNDERTAKER	ADDRESS
John C. Mitchell & Sons	1900 Eutaw Place

673 Spec.—2-29-28—L. F. S.—500 Bks.

E 48215 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 48215

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Chase St. & Park Ave ST., WARD) 11-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miriam R. Buzzell

(a) RESIDENCE NO. Brexton Apts. Chase ST., WARD
(Usual place of abode) & Parkland (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2 1897

7 AGE — Years: 31 | Months: 10 | Days: 6 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: school teacher

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Sparrows Point, Md.

PARENTS

10 NAME OF FATHER: Albert L. Buzzell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Bertha Lefever

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Mrs. Harry A. Buzzell

(Address): Brexton Apts. Park & Chase

15 Filed: C. HAMPSON JONES, M. D. Registrar

- 1929 -

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 4 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Aug 4, 1929, that I last saw h[illegible] alive on Aug 2, 1929, and that death occurred, on the date stated above, at 605 a. m.

The CAUSE OF DEATH* was as follows:

Melano Sarcoma

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Multiple Metastasis Parotid

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Nov - 28

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Section

(Signed) Francis D. Beattie, M. D.

Aug. 5, 1929 (Address) Reisterstown, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemy. — DATE OF BURIAL: Aug. 6, 1929

20 UNDERTAKER: John D. Mitchell & Son — ADDRESS: 1100 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 48216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 48216

REGISTERED NO.

1—PLACE OF DEATH 2321 Federal St.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2321 Federal ST., WARD)

2—FULL NAME Belle E. Standiford

(a) RESIDENCE NO. 2321 Federal ST., 1-16 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward Standiford

6 DATE OF BIRTH (month, day, and year) March 10, 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co., Md.

PARENTS

10 NAME OF FATHER Hudson Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant Mr. Edward Standiford

(Address) 2321 Federal St.

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 / 29

17

I HEREBY CERTIFY, That I attended deceased from August, 19xx, to Aug. 3, 1929.

that I last saw h.. alive on Aug. 3, 1929.

and that death occurred, on the date stated above, at 11:15 a. m.

The CAUSE OF DEATH* was as follows:

Chr. arterio-Sclerosis & Myocarditis
angina Pectoris
Chr. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signature) Isaac Templeton, M. D.

(Address) 290 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, REMOVAL Valley View Cemetery DATE OF BURIAL Aug 6 1929

20 UNDERTAKER David Dandeo ADDRESS Govans Md

Important: See instructions on back of certificate.

5 - 1929 HAMPSON JONES, P.

Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

E 48217.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 48217

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 921 E Hoffman ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothea Logue

(a) RESIDENCE NO. 921 E. Hoffman ST. 9-18 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15, 1928

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Logue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Agnes McEvoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. James Logue

(Address) 921 E Hoffman St.

15 Filed ... 19 ... Registrar

5-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929, to Aug 4th, 1929, that I last saw her alive on Aug 4th, 1929 and that death occurred, on the date stated above, at 7-30 P m.

The CAUSE OF DEATH* was as follows:

Acute Bacillus

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm Frame, M. D.

8-5-1929 (Address) 17 East Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Aug. 6, 1929

20 UNDERTAKER Rita Wakefield ADDRESS 914 Greenmore

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

22358 E 48218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 ✓ E 48218

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2—FULL NAME Theresa Campbell 6-9

(a) RESIDENCE NO. 1812 E. Fayette ST. St-6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-3-29

7 AGE: Years | Months 5 | Days 28 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Edward Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER Mary Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31-29

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 31, 1929

that I last saw her alive on July 31, 1929

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? YES

What test confirmed diagnosis? Phys Exam

(Signed) S. A. Bealestone, M. D.

Aug 3, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner of Health

ADDRESS AUG 5 - 1929

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109-002 E 48219

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis E Gibson. Jr

(a) RESIDENCE NO. 53 Henley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 2 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	child.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14-1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Gibson

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Theresa Hill

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New Jersey

14 Informant Hospital Record
(Address)

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M.D.

5-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/3/29

17 I HEREBY CERTIFY, That I attended deceased from 8/2, 1929, to 8/3, 1929

that I last saw h~~im~~ alive on 8/3, 1929

and that death occurred, on the date stated above, at 10 00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic tonsillitis and hypertrophied adenoids

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 8/3/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. O. Livingston, M. D.

8/3, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Aug 6th 1929
20 UNDERTAKER	ADDRESS
Robert Cowan & Son	Gorsuch Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 48220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 48220

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3937 Greenmount Ave St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Bagwell Wenn

(a) RESIDENCE NO. 3937 Greenmount AVE WARD 9-4

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
M.	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Wenn

6 DATE OF BIRTH (month, day, and year) June 24-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) B&O R.R. Co

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John F. Wenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Martha Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant E. L. Wenn

(Address) 2423 Westerdam Ave

15 Filed 5-1929, 19 G. HAMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 5-29, to Aug 5-29, that I last saw him alive on Aug 5-29, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Acute

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Guy V. Hoot, M. D.

, 19 (Address) 3957 Greenmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 7 19 29
20 UNDERTAKER	ADDRESS
D. Return Gore	1523 W Lafayette Ave

Spec.—140-21—M&T—1500 Bks.

E 48221 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48221

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH Cross Country Blvd and.

CITY OF BALTIMORE: (No. Pimlico Rd. ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Darby.

(a) RESIDENCE No. Cross Country Blvd + Pimlico Rd. St., WARD 27-54
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie O. Darby.

6 DATE OF BIRTH (month, day, and year): May 31 1881

7 AGE — Years: 48 — Months: 2 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Air brake Machinist
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country): Martinsburg W. Va.

PARENTS

10 NAME OF FATHER: Jas. B. Darby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Martinsburg W. Va.

12 MAIDEN NAME OF MOTHER: Ella M. Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Martinsburg W. Va.

14 Informant: Mrs Annie O Darby.
(Address) Cross Country Blvd + Pimlico Rd

15 [illegible] 19 [illegible] C. HAMPSON JONES, M. D. Registrar
BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/4 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/2 1929, to 8/4 1929, that I last saw h alive on 8/4 1929, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Locomotive Engineer B. & O.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Henry H. Cissel M. D.

(Address) 1215 Belvedere St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery — DATE OF BURIAL: Aug 7 1929

20 UNDERTAKER: Fuller Davis — ADDRESS: 3307 Fairmount St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EASE statement of cause of death
TION is very important. See instructions on back of certificates.

5 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48222

CERTIFICATE OF DEATH

E 48222

1—PLACE OF DEATH 1st Royal's Reservoir St — REGISTERED NO. 14-002

CITY OF BALTIMORE: (No. Druid Apt ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L. Mattoon

(a) RESIDENCE NO. Druid Apt ST., 13-20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Mulo

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 17th 1854

7 AGE — Years: 74 — Months: 7 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bangkok Siam

PARENTS

10 NAME OF FATHER: Stephen Mattoon

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Mary Lonsine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: R. L. Thomas

(Address): 803 St George Road

15 Filed ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 28 1929 to Aug 5 1929

that I last saw h alive on Aug 3 1929

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Arterial Embolus, right leg and probably Cerebral Embolus

(duration) — yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) Not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Phys. exam.

(Signed) Chas. J. Keller M. D.

Aug 6. 1929 (Address) 2 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edenvale N. C. — DATE OF BURIAL: Aug 6th 1929

20 UNDERTAKER: Henry Jenkins Sons Co — ADDRESS: Edenvale Pur Guilford Co

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—700 Bks.

E 48223 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48223

CERTIFICATE OF DEATH

X 159-003

REGISTERED NO. 48223

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD) 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Baer

(a) RESIDENCE NO. Ellicott City, Md ST., 4-30 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3 1929

7 AGE: Years 0 Months 7 Days 2 If LESS than 1 day, hrs. or min.

8 months

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott City

PARENTS

10 NAME OF FATHER John Baer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ethel Stonesifer

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or country)

14 Informant [illegible] Baer

(Address) Ellicott City

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-29

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1929, to August 5, 1929.

That I last saw h[illegible] alive on Aug. 5, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Shock following an operation for the repair of Congenital exstrophy of the bladder

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 5 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Luther E. Linn M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ulla Mfg.

DATE OF BURIAL: [illegible] 19 29

20 UNDERTAKER [illegible]

ADDRESS Ellicott City

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48224

CERTIFICATE OF DEATH

101-001 E 48224

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 638 N. Conway ST., WARD)

2—FULL NAME Alexander D. Haas

(a) RESIDENCE NO. 638 N. Conway ST. 22-30 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Alice Haas

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1870

7 AGE Years	Months	Days 22	If LESS than 1 day, ... hrs. or ... min.
58	8	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber.

(b) General nature of industry, business, or establishment in which employed (or employer) 59

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Falls, Md.

PARENTS

10 NAME OF FATHER Conrad Haas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Schirmer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Falls, Md.

14 Informant Alice Haas.

(Address) 638 N. Conway St.

15 Filed AUG 6 1929, 19 H. ANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5. 29

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929, to Aug. 5, 1929.

that I last saw h alive on Aug 4, 1929

and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

acute.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia - (Influenza).

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of no

Was there an autopsy? no.

What test confirmed diagnosis? Typical signs.

(Signed) James Wilson, M. D.

19 (Address) 1120 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 7, 1929

20 UNDERTAKER	ADDRESS
Mrs. Mrs. Tom H. Teufel & Son	801 N. Fayette St.

Important: See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Blks.

E 48225

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48225

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillie M. Legg

(a) RESIDENCE NO. 602 Scott St ST. 21-29 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion B. Legg

6 DATE OF BIRTH (month, day, and year) Aug 14. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Geo. F. Melvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Georgianna Fields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Marion B. Legg (Address) 602 Scott St

15 Filed AUG 5 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1929

17

I HEREBY CERTIFY, That I attended deceased from 7-30-29, 19 , to 8-4-29, 19 29.

that I last saw her alive on Aug 3 , 19 29.

and that death occurred, on the date stated above, at 8-4-29 2 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

a Heart affection

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By symptoms

(Signed) Arthur Kattenburg, M. D.

8/4. 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Aug 6 1929

20 UNDERTAKER Mrs Mrs. John M. Teufel & Son ADDRESS 801 W Fayette

CAUSE OF DEATH must be stated plainly. See that all items are answered. Use terms that will convey definite ideas. Do not use abbreviations or initials. Omit technical terms. Write so that a person not a physician can understand. IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48226
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

38 E 48226

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1459 N. Carey ST., WARD) 1, 23

2-FULL NAME Laura Smith

(a) RESIDENCE NO. 1459 N Carey ST., 15 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, ~~Married~~, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE — Years: 53 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer): 041
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): G. A. Co Md.

PARENTS

10 NAME OF FATHER: Edward Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince George Co.

12 MAIDEN NAME OF MOTHER: Charity Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): G. A. Co Md.

14 Informant: Lillie Howard
(Address): 1459 N. Carey St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1929

17
I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to Aug 3, 1929, that I last saw her alive on July 3, 1929, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann Positive

(Signed) J H Brown, M. D.

, 19 (Address) 704 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Aug 6 1929

20 UNDERTAKER: Virginia A. Brooks — ADDRESS: 1463 N. Carey

TION is very important. See instructions on back of certificates.

AUG 6 1929 DARGAN JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48227

CERTIFICATE OF DEATH

31

E 48227

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 E 29th ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Horace P. Wolf

(a) RESIDENCE NO. 1916 E. 29th ST., 9-46 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 3 mos. 30 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced BUSBAND of (w[illegible]) Loretta Wolf

6 DATE OF BIRTH (month, day, and year) April 5th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Credit Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Armour & Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Charles P Wolf

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Emma Suess

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Loretta Wolf
(Address) 1916 E 29th St

15 Filed Aug 6 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Aug 4, 1929, that I last saw h[illegible] alive on Aug 4, 1929 and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Chronic with Phthisis
Pulmonary Endurance
a number of years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Boyd, M. D.

Aug 6th, 1929 (Address) 1416 E Oliver Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 7th 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1826 E Monument St

Cor.—12-9-25—A Co.—200 Bks.

E 48228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 E 48228

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Marine Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George T. Williams

(a) RESIDENCE NO. 2824 Pelham Ave. Ward 8-45

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Josephine Williams

6 DATE OF BIRTH (month, day, and year) Aug 3/78

7 AGE — Years: 51 — Months: — Days: 1 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tug Boat Captain

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER Jonathan Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Josephine Williams

(Address) 2824 Pelham Ave

15 Filed ..... 19 ..... G. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal Hemorrhage

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

(Coroner)

(Address) 2 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Date of Burial: Aug 7 1929

20 UNDERTAKER: Philip Herring ADDRESS 206 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48229

CERTIFICATE OF DEATH

90

REGISTERED NO. E 48229

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3354 Chestnut Ave ST. WARD 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Archibald Jardine

(a) RESIDENCE NO. 3354 Chestnut Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel Jardine

6 DATE OF BIRTH (month, day, and year) Nov 22 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Archi Jardine

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Jane Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Lottie E. Jardine

(Address) 3354 Chestnut Ave

15 Filed AUG 6 - 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Jun 1 1929 to Aug 3 1929

that I last saw him alive on Aug 2 1929

and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 7 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) C. F. Cruzat M. D.

2-3-29 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Aug 6 1929
20 UNDERTAKER	ADDRESS
Ehenowethon	[illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

E 48230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 48230

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 306. E 23rd ST., WARD)

2—FULL NAME Annie. E. Plummer

(a) RESIDENCE NO. 306. E. 23rd ST., WARD 7-50

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Ff.	Col	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Plummer

6 DATE OF BIRTH (month, day, and year) Oct 28 94

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte Co Va

PARENTS

10 NAME OF FATHER Henry Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bettie Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Plummer

(Address) 306. E. 23rd St

15 Filed AUG 6 1929, 19.. H. LESLIE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5. 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1929, to Aug 6, 1929, that I last saw her alive on Aug 5, 1929 and that death occurred, on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) W. D. Bull, M. D.

8-5, 19.. (Address) 1426 E 23rd St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Riverside Va	Aug 7 19 29
20 UNDERTAKER Jim W. Carpenter	ADDRESS Ho Market

Spec.—2-29-28—L. F. S.—500 Bks.

Mettam.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48231

CERTIFICATE OF DEATH

74-001

E 48231

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3113 Windsor ave WARD)

2—FULL NAME Annie B. Mettam 15-61

(a) RESIDENCE NO. 3113 Windsor ave. 15-61 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Clay Mettam

6 DATE OF BIRTH (month, day, and year): Apr 9. 1851

7 AGE — Years: 78 — Months: 3 — Days: 26 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Phila. Pa.

PARENTS

10 NAME OF FATHER: Joshua Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Anna M. Riddiker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Charlotte Dick

(Address): 2908 Windsor ave

15 Filed ..., 19 ... Registrar: C. HAMPSON JONES, M.D.

S-1998

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug 5-29

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to aug. 5, 1929, that I last saw h[illegible] alive on aug. 1, 1929, and that death occurred, on the date stated above, at 9. a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (2 stroke)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): arterio sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination - urinary analysis

(Signed) H. H. Stansbury, M. D.

(Address) 714 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr 7 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	Pleas[illegible] Ave Entrance

Spec.—2-29-28—L. P. S.—500 Blks.

E 48232 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 48232

CERTIFICATE OF DEATH 31

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Wilson

(a) RESIDENCE NO. 1632 N. Gilmor st. ST., 15-21 WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 17

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed 6-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to August 2, 1929, that I last saw him alive on August 2, 1929, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Hospital M. D.

8-3, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 6 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Pulaski St.

Cor.—10-10-29—A Co.—100 Bks.

E 48233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48233

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 421 N. Carrollton ave St., 17-26 Ward)

2-FULL NAME Horace West

(a) RESIDENCE NO. 421 N. Carrollton ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Isabelle West

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab—
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 0 40

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Lewis West

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Isabelle West
(Address) 421 N Carrollton ave

15 Filed Aug 6 1929 19 C. HAMPSON JONES, M. D. Registrar

By SHG

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

Aug 3. 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug. 6, 1929
20 UNDERTAKER	ADDRESS 372 N
Mrs. Kate R Williams	Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Milton Reely

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48234 ✓ X 29 E 48234

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milton Reely

(a) RESIDENCE NO. Savage, Md. 4-30 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Child

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Reely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Father

(Address)

Filed DEC 6 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1929, to Aug 6, 1929, that I last saw h[illegible] alive on Aug 6, 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Tetanus

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Buccinator wound Pt had by a splinter (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Savage, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W B Knapp, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savage Md	Aug 8 1929
20 UNDERTAKER	ADDRESS
Long Kaiser	Baltimore

Cor.—10-10-29—A Co.—100 Bks.

E 48235

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48235

CERTIFICATE OF DEATH

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., Ward)

2-FULL NAME Jacob Cooper

(a) RESIDENCE No. 30 S. Bond. St., 3-4 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Col.

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced, BUSBAND of (or) WIFE of: Josephine Cooper

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years 82; Months; Days; IF LESS than 1 day ...hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Ship Caulker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Jos. Cooper
(Address) 1152 Edmondson

15 Filed ... 1929 — AUG 6 - 1929 — HAMILTON JOHNS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to his death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
Cerebral Hemorrhage
(Apoplexy)
(duration) ... yrs. ... mos. ...
CONTRIBUTORY (Secondary) Fractured Radius & Ulna, (fell down steps)
(duration) ... yrs. ... mos.

If Where was disease contracted if not at place of death? 30 S. Bond St.

Did an operation precede death? No Date of

Was there an autopsy? No

What lesl confirmed diagnosis? Regular

(Signed) H. Heinitz Coroner, M. D.

Aug 5 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cem — DATE OF BURIAL: 8-7 1929

20 UNDERTAKER: Bynow & Wright — ADDRESS: 1218 McElderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 48236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 48236

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3050 Arunah Ave ST., WARD)

2-FULL NAME Dorothy Heilman Hayden

(a) RESIDENCE No. 3050 Arunah ST., Ave WARD 70

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 8, 1890.

7 AGE: Years 39 Months — Days 27 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Heilman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Schwarz

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Geo G Hayden

(Address) 3050 Arunah Ave

15 Filed AUG 6 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1 1929 to Aug 5 1929, that I last saw h alive on Aug 5 1929 and that death occurred, on the date stated above, at 5.50 Pm

The CAUSE OF DEATH* was as follows:

Endocarditis
Myocarditis
Chronic Nephritis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of no

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Herman A Voigt, M. D.

, 19 (Address) 5106 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug 8 1929

20 UNDERTAKER: Geo W. Little — ADDRESS: 2701 Edmondson Ave

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

48237

CERTIFICATE OF DEATH.

× 43 E 48237

1-PLACE OF DEATH St. Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Wilkins Ave. ST. WARD)

2-FULL NAME Mrs. Peter Robert Cobble

(a) RESIDENCE NO. Greensboro N.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Cobble

6 DATE OF BIRTH (month, day, and year) Dec 17 1841

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Guilford Co
(State or country) North Carolina

PARENTS

10 NAME OF FATHER Geo Cobble

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Thirza M. Hamm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Mrs. Cobb
(Address) Greensboro N.C.

15 Filed — 19 — Registrar

AUG 6 1929 H. HAMPTON GITTINGS, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 19 29

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 19 29 to Aug 5 19 29.

that I last saw h alive on Aug 5 19 29

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Myocarditis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma tongue

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Oscar K. Bonsella M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro N.C.

DATE OF BURIAL 19

20 UNDERTAKER Geo W Little

ADDRESS

TION IS very important. See instructions on back of c

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48238

CERTIFICATE OF DEATH

90 E 48238

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Fiske

(a) RESIDENCE NO. 310 W. Mulberry ST. 4-25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fem	Wht	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Record
(Address)

15 Filed ....., 19.. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/29

17 I HEREBY CERTIFY, That I attended deceased from 1/17, 1921, to 8/4, 1929.

that I last saw her alive on 8/3, 1929

and that death occurred, on the date stated above, at 12 00 a.m.

The CAUSE OF DEATH* was as follows:

Senility - Arteriosclerotic cardiovascular disease

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Thompkins, M. D.

8/4, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 8/6 1929

20 UNDERTAKER Wm. Cook — ADDRESS 1217 St. Paul St.

Cor.—10-10-29—A Co.—100 Bks.

E 48239

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48239

CERTIFICATE OF DEATH

188-103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Balto Hosp. Ward)

2-FULL NAME Mildred I Antich

(a) RESIDENCE NO. 5237 Clarke Ave Ward 28-63

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 25-1912

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	17	1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Arlington Laundry Co
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Ernest C Smith

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Hannie Euser

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ernest C Smith
(Address) 5237 Clarke Ave

15 Filed [illegible] 19 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-4 1929

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Ruptr Brachial Artery - R
Perfect wound L. Axilla along
Costal Margin (dupl)

If (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage & Shock
Where? riding on running board of automobile

If operation, (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Franz M. D.

8-6, 1929 (Address) 2939 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	8/7 1929
UNDERTAKER: D. Wellington Cook	ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48240

CERTIFICATE OF DEATH.

90

E 48240

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1434 E. Fayette ST., WARD)

2-FULL NAME Maggie Travis

(a) RESIDENCE NO. 1434 E. Fayette ST. 5-9 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Travis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edna Travis

(Address) 1434 E. Fayette

15 Filed AUG 6 - 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3- 1929

17

I HEREBY CERTIFY, That I attended deceased from 6-27- , 1929, to 8-3- , 1929,

that I last saw her alive on 8-2- , 1929,

and that death occurred, on the date stated above, at 4.15 A m

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

unknown.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm. H. Gangier, M. D.

8-6-, 1929 (Address) 611 N. Carol

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

M. Calvary cemetery aug 6 1929

20 UNDERTAKER — ADDRESS

R A Elliott [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

TION is very important

E. HAMPTON JONES, M.D.

Spec.-7-17-26—A Co.—200 Bks.

E 48241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 48241

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 833 S. Kenwood Ave. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Gramens

(a) RESIDENCE NO. 833 S. Kenwood Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER Alexander Gramens

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Bertha Legrdzyn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Del

14 Informant Mrs. Josephine Legrdzyn

(Address) 833 S. Kenwood Ave.

15 Filed 8-6-1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5, 1929 19

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929 to Aug. 5, 1929

that I last saw her alive on Aug. 5 1929

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. 10 mos. da.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronusnas, M. D.

8-5-29 19 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
St. Stanislaus Cemetary	8-6- 1929

20 UNDERTAKER Stephan Fialkowski, Inc. ADDRESS 1000 S. Kenwood Av

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 48242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48242

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4309 Arabia av St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Weaver

(a) RESIDENCE NO. 4329 Arabia av St. 27-44 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 11 mos. 12 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilhelmina B. Weaver

6 DATE OF BIRTH (month, day, and year): Aug 22nd 1852

7 AGE — Years: 76 Months: 11 Days: 12

IF LESS than 1 day ____ hrs. or ____ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William C. Weaver

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germy.

12 MAIDEN NAME OF MOTHER: Sophia P Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: Wilhelmina B. Weaver

(Address): 4309 Arabia av.

15 Filed Aug 6 1929 R P K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1927 to Aug 4th 1929

that I last saw h[illegible] alive on Aug 3rd 1929

and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) [illegible], M. D.

8-4, 1929 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem Date of Burial: Aug 7th 1929

20 UNDERTAKER: E Schlosser & Son ADDRESS: 32[illegible] Baltimore

[illegible] be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48243

CERTIFICATE OF DEATH

49

E 48243

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 S.Charles ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Schaefer

(a) RESIDENCE NO. 1626 S.Charles ST. 23-37 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 11 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E.Schaefer

6 DATE OF BIRTH (month, day, and year) Aug.8 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	28	27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Upholsterer $5 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Toepfer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J.Harry Schaefer

(Address) 1626 S.Charles St.

15 Filed AUG 6 - 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.5 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1927, to Aug 5, 1929, that I last saw h alive on Aug 5, 1929 and that death occurred, on the date stated above, at 10.15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Penis

Independent (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

Aug 6 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 8 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48244

E 48244

74-001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 770 W. Lexington St St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvin N. McAllister

(a) RESIDENCE NO. 770 W. Lexington St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) February 25 1861

7 AGE	Years	Months	Days 10	IF LESS than 1 day.....hrs. or.....min.
	68	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Photographer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Jas. A. Mc. Allister

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Eliza J. Webster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dorchester Co. Md.

14 Informant James A. Mc. Allister

(Address) Cambridge, Md.

15 Filed A. G. O. 19 Registrar

AUG 6 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Augs 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (secondary) Exhaustion

(duration) yrs. mos. ds.

Witnessed by Dr. G. Slades (Coroner) M. D.

6-19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md. Via B&A

Date of Burial Aug 6 1929

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

48245

CERTIFICATE OF DEATH

44

E 48245

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 S. Potomac ST., WARD) 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian M. Ramey

(a) RESIDENCE NO. 1124 S. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John H. Ramey

6 DATE OF BIRTH (month, day, and year): Oct. 3-1872

7 AGE: Years 56 | Months 10 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York.

PARENTS

10 NAME OF FATHER: dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country): dont know

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): dont know

14 Informant: Jone L. Ramey (Resd)

(Address) 3124 Foster ave

15 Filed AUG 8 1929 19 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 6. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15 1929 to Aug 6 1929

that I last saw her alive on August 1. 1929

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinomatous Ascites

Intestinal Obstruction (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? yes Date of 6-8-29

Was there an autopsy? yes

What test confirmed diagnosis? inspection of growth

(Signed) Edward S. Johnson M. D.

8/6 1929 (Address) 1212 St Paul St, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: aug 8 1929

20 UNDERTAKER: George W. Zirkler — ADDRESS: 1737 Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 48246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

48 E 48246

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Milton ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael J. Cain

(a) RESIDENCE NO. 507 N. Milton ave ST. 9-10 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 74				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore

(c) Name of employer City 040

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Cain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Cain

(Address) 507 N. Milton ave

15 Filed Aug 5, 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1929, to Aug. 4, 1929, that I last saw him alive on Aug. 2, 1929 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Duodenum)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene F. Cullen, M. D.

Aug 5, 1929 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Aug 7, 1929

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48247

CERTIFICATE OF DEATH

31

E 48247

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 8h Post St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earl B. Mathews

(a) RESIDENCE NO. 8h. Post ST. 6-10 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mns. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S.

.a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 9-1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph A Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mollie Sallo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jos A. Mathews

(Address) 8h. Post St

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D.
6-1929 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3-1929

17 I HEREBY CERTIFY, That I attended deceased from July 7" 1929 to August 3 1929

that I last saw h[illegible] alive on August 3" 1929

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Caleb N. Athey, M. D.

Aug 5, 1929 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Aug. 7, 1929

20 UNDERTAKER John F. Moran — ADDRESS 3000 E. Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 48248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 43248

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Brown

(a) RESIDENCE NO. 328 W. Hoffman ST., 11-24 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lavia Brown

6 DATE OF BIRTH (month, day, and year) ? 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?
(State or country) Va.

PARENTS

10 NAME OF FATHER Chester Brown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Francis

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant Records of BALTIMORE CITY HOSPITALS
(Address)

15 Filed 6-1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-26, 1929, to 8-3, 1929, that I last saw him alive on 8-3, 1929, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension; Pneumonia (Lobar)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.C. Path.

(Signed) Marvin M. McLean, M. D.

8-4, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	Aug 6 1929

20 UNDERTAKER Samuel Wenselaus Biddle ADDRESS 539

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48249 ✓ E 48249

CERTIFICATE OF DEATH

113

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1038 Wilcox ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence E. George

(a) RESIDENCE NO. 1038 Wilcox ST., 10-14 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 11 ds. How long in U. S., if foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Sngl.

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	11 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Stephen A. George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine Barry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs. Catherine Barry

(Address) 1038 Wilcox St

15 Filed 6-1929, 19 R K H Registrar

C. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1929

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1929, to Aug 2, 1929, that I last saw her alive on Aug 2 1929 and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea

(duration) yrs. mns. ds.

CONTRIBUTORY (Secondary) Neglect

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

Aug 6, 1929 (Signed) Thomas Rooman M. D.

(Address) 1001 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug. 7 1929
20 UNDERTAKER Henry Koch Sons Inc	ADDRESS 1301 E Eager St

Spec.—1-10-21—MAT—1500 Blks.

E 48250

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48250

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST., WARD)

2-FULL NAME Sister Mary Dionede Donahue

(a) RESIDENCE NO. 901 Aisquith Street ST., 10-14 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of +

6 DATE OF BIRTH (month, day, and year) 4 March 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Religious 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. John New Brunswick

PARENTS

10 NAME OF FATHER James Donahue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Mary Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Sisters of Notre Dame (Address)

15 Filed . 19 Registrar

C. HAMPSON JONES, M. D.

6 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 August 1929

17 I HEREBY CERTIFY, That I attended deceased from July . 1928 . to August 4 . 1929 .

that I last saw h er alive on August 4 . 1929 .

and that death occurred, on the date stated above, at 11 a.m. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

Metastasis Spinal Cord

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Local Breast

Did an operation precede death? Yes Date of 1925

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) F. Fink M. D.

8/6 . 1929 (Address) 1106 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loch Cliff Md. DATE OF BURIAL Aug 7 1929

20 UNDERTAKER Frank A. Fink ADDRESS 1151 E Gay St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48251 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

38 E 48251

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. West Baltimore Gen. Hospital ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Thomas E. Sawyer.

(a) RESIDENCE NO. 2601 Kate ave ST. 15-58 WARD
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Sawyer.

6 DATE OF BIRTH (month, day, and year) Sept 11, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
48		10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) 634
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk County, Virginia

PARENTS
10 NAME OF FATHER Wm. J. Sawyer.
11 BIRTHPLACE OF FATHER (city or town) Nansemond. (State or country) Virginia
12 MAIDEN NAME OF MOTHER Emma C. Sawyer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Mary E Sawyer
(Address) 2601 Kate ave

15 Filed 6 6 - 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15th, 1929, to Aug 6th, 1929.
that I last saw him alive on Aug 6th, 1929.
and that death occurred, on the date stated above, at 5.15a.m.
The CAUSE OF DEATH* was as follows:

Syphilitic Cardio-vascular Disease., with aortic insufficiency and chronic passive congestion
(duration) 3 yrs mos ds.
CONTRIBUTORY (Secondary) Cardiac dilatation
(duration) yrs mos 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical & Laboratory.
(Signed) J. H. Hodgins M. D.
, 19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL Aug 8 1929

20 UNDERTAKER W M Rinkins — ADDRESS 2238 N Howard

HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48252

CERTIFICATE OF DEATH

118-001 E 48252

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Md. Gen. Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary C Beard

(a) RESIDENCE NO. 2447 Barclay St. 17-50 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Beard.

6 DATE OF BIRTH (month, day, and year) July 1 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Hospital Record
(Address)

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8. 5. 29

17 I HEREBY CERTIFY, That I attended deceased from 8. 3. 29, 19..., to 8. 5, 19 29

that I last saw h.. alive on 8. 5, 19 29

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Rt. Inguinal Hernia with beginning strangulation with intestinal obstruction

(duration) ... yrs. ... mos. 1 ds.?

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) ... yrs. ... mos. 1 ds.?

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 8. 3. 29

Was there an autopsy? no

What test confirmed diagnosis? C. Clinical

(Signed) S. Robert Wells M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bridesburg burial Grd	Aug 8 1929
20 UNDERTAKER	ADDRESS
W M Routson	2238 N Monti

1929

Spec.—1-12-23—M&T—500 Blks.

E 48253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 48253

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., WARD)

2-FULL NAME Ernest Olsen.

(a) RESIDENCE No. 11 W. Mt. Vernon Pl. ST 11-25 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11 86

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or..... min.
42	10	21	24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Barton Jones. 0/0

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Ole P Person

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Larson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Lydia C Larson

(Address) 1053—5th New York

15 Filed Aug 6, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to August 5, 1929, that I last saw him alive on August 5, 1929, and that death occurred, on the date stated above, at 7:35 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the oesophagus

about (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of residence

Did an operation precede death? Yes Date of May 10, 1929

Was there an autopsy? Gastrostomy. No

What test confirmed diagnosis? None

(Signed) W. W. Elgin, M. D.

8/5, 1929 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Port R. I.

DATE OF BURIAL Aug 6 1929

20 UNDERTAKER Wm Routson

ADDRESS 2230 W Mt Vernon Pl

TION IS VERY Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48254

1-PLACE OF DEATH

CERTIFICATE OF DEATH

90

E 48254

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Baltimore City Jail St., Ward)

2-FULL NAME Carl P. E. Mansson.

(a) RESIDENCE NO. Do not know. St., 10-15 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth 15 yrs. mos. ds.

(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) December 11, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	46	7	25 24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Copenhagen,
(State or country) Denmark.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant William Severe.
(Address) Fort McHenry.

15 Filed 6 1929, 19 C. HAMPSON JONES, M. D., Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Inquiry

(Signed) Otto M Steinhardt M. D.

8/6 . 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Crm	8/7 1929
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Baltimore Md.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48255

CERTIFICATE OF DEATH

74-001 E 48255

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida V. Harris.

(a) RESIDENCE NO. 428 E. Lafayette ave ST. 12 WARD 9

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Harris

6 DATE OF BIRTH (month, day, and year) Mar 9 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster (State or country) Md

PARENTS

10 NAME OF FATHER William P. Yingling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER F. Ellenora Frisk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant William Harris

(Address) 428 E. Lafayette ave

15 [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/29

17

I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to Aug 5, 1929, that I last saw her alive on Aug 5, 1929 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation (acute).

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Cause

(Signed) [illegible] M. D.

19 (Address) [illegible] Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Cem Carroll County Westminster	Aug 8 1929

20 UNDERTAKER Mrs C. Miller & Son ADDRESS 233 [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

E 48256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 48256

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 415 N. Ellwood Ave ST., WARD)

2—FULL NAME Lawrence Woffman

(a) RESIDENCE NO. 415 N Ellwood Ave ST., 6-11 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Woffman

6 DATE OF BIRTH (month, day, and year) Aug 8 - 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	3	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Lawrence Woffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Emma Forel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E Woffman
(Address) 415 N Ellwood Ave

15 Filed ....., 19 C. HAMPSON JONES, M. D. - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 - 1929

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to Aug 5, 1929, that I last saw h[illegible]live on Aug 5 1929 and that death occurred, on the date stated above, at 4-37 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx (Primary)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Gorl, M. D.

8/5, 1929 (Address) 415 N Wooshington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Aug. 8 1929
20 UNDERTAKER	ADDRESS
Wm. E. Miller & Son	2334 Gilmor St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48257

CERTIFICATE OF DEATH

185 E 48257

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md. Gen Hosp. St., Ward)

2-FULL NAME John A. Porter.

(a) RESIDENCE NO. 3507 Walbrook St., 15-67 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melanie

6 DATE OF BIRTH (month, day, and year) Apr 15-1845

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	84	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wesley Porter

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Owens

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John L. Porter
(Address) 3507 Walbrook

15 Filed Aug 8 1929 19 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:* Accident in ballroom (Over)
Cerebral Hemorrhage
(duration) 2 yrs. 1 mos. 1 ds.
CONTRIBUTORY (Secondary) Fractured Femur
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Edgewood Sanatorium

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Hoffman, M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Park Lake	Aug 8-1929

20 UNDERTAKER J. Fenwick Lee ADDRESS 723 W. Lafayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

6

Spec.—2-29-28—L. F. S.—500 Blks.

E 48258 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

90 E 48258

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3814 White Ave ST., WARD) 27-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma C. Jones

(a) RESIDENCE NO. 3814 White Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 1 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 2 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Alfred H. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah J. Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs James Patchet

(Address) 3814 White ave

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5-1929

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1929 to aug 5, 1929 that I last saw her alive on August 3, 1929 and that death occurred, on the date stated above, at 10-20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

several years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

many years (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

8/6, 1929 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakdawn Cemetery	Aug 1929
20 UNDERTAKER	ADDRESS
Wm C. Black	927 N. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 48259

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48259

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Preice ST., WARD) 17-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Ward.

(a) RESIDENCE NO. St. Joseph's Hospital ST., Caroline & Alvin WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Catherine Herron

(Address) 304 Caroline ave

15 Filed G 7 1929 19 H. BRYAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1929, to Aug. 5, 1929

that I last saw him alive on Aug. 5, 1929

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Post Mortem.

(Signed) H B Schubert, M. D.

(Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt auburn	8 7 1929
20 UNDERTAKER D. Samuel Kahn	ADDRESS 86 Ostego

Spec.—2-29-28—L. F. S.—500 Bks.

E 48260

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 48260

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore city Hosp, ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Lutz

(a) RESIDENCE NO. 2009 Fenmore Ave ST., 20 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 16 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 162

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Gerhardt Lutz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Berger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/6/29

17 I HEREBY CERTIFY, That I attended deceased from 7/23, 1929, to 8/6, 1929, that I last saw h[illegible] alive on 8/6, 1929, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right arm

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Metastases to lungs

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

8/6, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lowson Park Cem	Aug 8 1929
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Eutaw St

Spec.—2-29-28—L. F. S.—500 Blks.

E 48261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48261

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3126 Abell Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Clark

(a) RESIDENCE NO. 3126 Abell Ave ST., 12-50 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Harry J. Clark.

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ellicott City Maryland.

PARENTS

10 NAME OF FATHER Thomas Duffy

11 BIRTHPLACE OF FATHER (city or town) Ellicott City (State or country) Howard Co., Md.

12 MAIDEN NAME OF MOTHER Kate Harden

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or country) Howard Co., Md.

14 Informant Mrs. Alma Winne

(Address) 3120 Abell Ave.

15 Filed AUG 7 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to Aug. 6, 1929, that I last saw her alive on Aug. 5, 1929 and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) E. W. Sickel, M. D.

8/6, 1929 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug. 8 1929
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W. Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

E 48262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185

E 48262

REGISTERED NO.

1-PLACE OF DEATH Univ. Hospital

City of BALTIMORE: (No. Lombard St Greene St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Smith

(a) RESIDENCE NO. 659 George St 17-25 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE: Years 35 Months Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Construction

(c) Name of employer Francis Harley Bros.

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) N. C.

(State or country)

12 MAIDEN NAME OF MOTHER Emily Jane Naylor

13 BIRTHPLACE OF MOTHER (city or town) N. C.

(State or country)

14 Informant Estye Smith

(Address) Cameron N. C.

15 Filed ..... 19 H. LAWSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Decompensation Paralysis Fractured Skull - Fracture of Base Transection of Spinal cord Fractured Scapula (duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. 10 ds.

(Signed) H. C. Slade M. D.

18 (Address) Cameron N C Route 1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. 15 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

If former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cameron N C Date of Burial Aug 7 1927

20 UNDERTAKER Samuel T. Newsley ADDRESS Biddle

OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Berger

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48263 49 E 48263

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., WARD)

2—FULL NAME Joseph Berger

(a) RESIDENCE NO. 730 N. Fay ST., 10-14 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John L. Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Eliz. Docke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record
(Address)

15 Filed Aug 7 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5/29

17 I HEREBY CERTIFY, That I attended deceased from 7/16, 1929, to 8/5, 1929,

that I last saw h[illegible] alive on 8/5, 1929

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma bladder - hydro-nephrosis -

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. G. Lumpkin, M. D.

8/6, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

(Over)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 7 1929
20 UNDERTAKER Robt J. Turner	ADDRESS 1452 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

48264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 48264

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2738 Hugo Ave. ST., WARD)

2-FULL NAME Benjamin Franklin Gray.

(a) RESIDENCE NO. 2738 Hugo Ave ST., 9-46 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white.	widowed.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Agnes Loretta Gray.

6 DATE OF BIRTH (month, day, and year) March 12, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	4	25 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) ~~Unknown~~

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mr. John W. Gray (Son)
(Address) 2739 Hugo Ave

15 Filed Aug 9 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to August 6, 1929, that I last saw him alive on August 5, 1929, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Epithelioma Pharynx.

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cachexia.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Chas. Wilbur Stewart, M. D.

8/6, 1929 (Address) 1738 E. 28th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks cemetery	Aug 8 1929
20 UNDERTAKER Robt L. Turner	ADDRESS 1442 N Broadway

TION is very important. See instructions on back of certificates.

Form No. 10 Co.—200 Blks.

48263 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

56 E 48265

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 907 N. Belnord St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Jankiewicz

(a) RESIDENCE NO. 907 N. Belnord Ave St. 1-3 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 26 1929

7 AGE Years 0 Months 6 Days 11

If LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country)

PARENTS

10 NAME OF FATHER: John Jankiewicz

11 BIRTHPLACE OF FATHER (City or town): Balto.

(State or country)

12 MAIDEN NAME OF MOTHER: Alexandra Olejniczak

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country)

14 Informant: John Jankiewicz

(Address): 907 N. Belnord Ave

15 Filed AUG 7 - 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4 1929 to Aug. 6 1929 that I last saw him alive on Aug. 6 1929 and that death occurred, on the date stated above, at 12:40 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Rickets (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Gaynitsch M. D.

19 (Address) 735 S. Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr. Hamilton Cem. Date of Burial: Aug 7 1929

20 UNDERTAKER: Stephen D. Finkowski ADDRESS 1100 S. Ann St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

182 E 48266

E 48266

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Water around Fort Land St. Ward)

2-FULL NAME Geo M. Makauskas

(a) RESIDENCE NO. 702 W Lombard St., 4-29 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug. 23. 1911

7 AGE 17 Years 11 Months 4 Days 11 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) no
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph makauskas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER
K. Salkute

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Joseph makauskas
(Address) 702 W Lombard St

15 Filed [illegible] 1929 H. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc
Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? —
If not at place of death?

Was operation preceded death? — Date of —

Was there an autopsy? [illegible]

What test confirmed diagnosis? Eyes

(Signed) [illegible] M. D.

1929 (Address) 1 E 22 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 8, 1929

20 UNDERTAKER	ADDRESS
John Gebbiauckas	423 S Pac

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48267

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 S Wolfe ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Victoria Dora Ricardo

(a) RESIDENCE NO. 574 S Montford ave ST., 1-3 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Tony Ricardo

6 DATE OF BIRTH (month, day, and year): Oct 30 1873.

7 AGE: Years 55 Months 9 Days 6. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Tony Ricardo

(Address) 916 S Wolfe st

15 Filed AUG 7 - 1929

[illegible] JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 5 - 1929

17 I HEREBY CERTIFY, That I attended deceased from August 4 1929, to August 5, 1929, that I last saw h[illegible] alive on August 5, 1929 and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Valvular Heart disease

(duration) 2 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) myocarditis, acute dilatation of heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical findings and symptoms

(Signed) Samuel Silverstein M. D.

, 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Aug 6 1929
20 UNDERTAKER	ADDRESS
Geo. A. Weber	705 S. Amity

Spec.—2-29-28—L. F. S.—500 Bks.

2 2E7 48268

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109-002 E 48268

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Von Storch

(a) RESIDENCE NO. 1702 E Northwest ST., 8-17 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

-a If married, widowed, or divorced HUSBAND of (or) WIFE of Theo

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Colorado

PARENTS

10 NAME OF FATHER Chas. Reiferting

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Martha Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 7 1929 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1929, to Aug 6, 1929, that I last saw her alive on Aug 6, 1929 and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Oedema of ~~throat~~ Pharynx
Pressure of tissues on trachea
Cellulitis (Staphylococcus hemolyticus)
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Septicemia (Staphylo. hemolyticus)
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? following extraction of tooth

Did an operation precede death? Yes Date of 8/3/29

Was there an autopsy? Yes

What test confirmed diagnosis? bacteriological

(Signed) Ferdinand Reis, M. D.

8/6, 1929 Address Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 7 19 29

20 UNDERTAKER John O. Whitehurst & Associates ADDRESS Place

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48269

CERTIFICATE OF DEATH

x 129 E 48269

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Houstad Fleming 4-30

(a) RESIDENCE NO. Cardiff, Md. 5 days WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	61 yrs.	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer in cattle 045

(b) General nature of industry, business, or establishment in which employed (or employer) Sold cows & horses

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Chester (State or country) W. Penn.

PARENTS

10 NAME OF FATHER Wm. A. Fleming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chester Co. Penn.

12 MAIDEN NAME OF MOTHER Rose Houston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co. Penn.

14 Informant Wm. F Fleming

(Address) 3 and V. N. Wolfe St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Aug 6, 1929, that I last saw him alive on Aug 6, 1929, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy with acute retention.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis, hypertension (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical data & Autopsy.

(Signed) Luther E. Leith, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tagg's Manor Pa.	Aug 7, 1929
20 UNDERTAKER	ADDRESS
Harry A. Wilke	15 31 W. Lombard St.

Spec.—2-29-28—L. F. S.—500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48270

CERTIFICATE OF DEATH

117 E 48270

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamin F. Pierpoint, Sr. Benjiman F Pierpont

(a) RESIDENCE NO. 109 S. Schroeder ST., 18-29 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosina Bury Pierpoint

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1857.

7 AGE Years	Months	Days 28	If LESS than 1 day, hrs. or min.
71	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired, Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 854

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Pierpoint

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. B. F. Pierpoint

(Address) 109 S. Schroeder St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to August 5, 1929, that I last saw him alive on August 5, 1929 and that death occurred, on the date stated above, at 5:05 A m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis, with abcess.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Helms, M. D.

8/5, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug. 8, 19 29
20 UNDERTAKER Harry S. Mitchell	ADDRESS Amherst St

Spec.—1-12-23—M&T—500 Bks.

Schaar

E 48271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/4-00 E 48271

1-PLACE OF DEATH 3612 McYamish Ave REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., WARD) 25-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Schaar

(a) RESIDENCE NO. 3612 McYamish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Alois Schaar

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Georg Rimbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Feher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Walter A. Schaar

(Address) 3123 Wilkens Ave.

15 Filed AUG 7 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to Aug 6, 1929, that I last saw alive on Aug 6, 1929 and that death occurred, on the date stated above, at 7:25 p.m.

The CAUSE OF DEATH* was as follows:

Generalized arterio-sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl. Phy

(Signed) F. T. Kyper, M. D.

, 19 (Address) 3321 Forest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park — DATE OF BURIAL 8/8/29

20 UNDERTAKER Harry N. Wetzel — ADDRESS 1531 W. Lombard St.

THIS IS Very Important—See instructions on Back of Certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Joyce.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48272

CERTIFICATE OF DEATH

113

REGISTERED NO. [illegible]

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

2—FULL NAME Baby Maria Joyce

(a) RESIDENCE NO. 742 W. Balto ST., 4-26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work — Hse. [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Nsme of employer —

9 BIRTHPLACE (city or town) Balto, Md
(State or country)

PARENTS

10 NAME OF FATHER Harry Joyce

11 BIRTHPLACE OF FATHER (city or town) Balto, Md
(State or country)

12 MAIDEN NAME OF MOTHER Cecilia Kowalewska

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md
(State or country)

14 Informant Mother: 742 W Balto St.
(Address)

15 Filed DEC 7 1929, [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6, '29

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to Aug. 6, 1929, that I last saw h alive on Aug 6, 1929 and that death occurred, on the date stated above, at 7:50 A.m.

The CAUSE OF DEATH* was as follows:

Entero-colitis, pyelitis, otitis media.

Broncho-pneumonia.

(doration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Happy Hills

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H Sanford, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Aug 8th, 1929
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48273 ✓ E 48273

E 48273

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1015 Aisquith ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Hebrank

(a) RESIDENCE NO. 1015 Aisquith ST., 10 WARD 10-14

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. — mos. — ds. How long in U. S., if foreign birth 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Bernardine Hebrank

6 DATE OF BIRTH (month, day, and year) Aug. 18 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Pa.

PARENTS

10 NAME OF FATHER Henry Hebrank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elizabeth Hebrank

(Address) 1015 Aisquith St

15 Filed 7-1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1929

17 I HEREBY CERTIFY, That I attended deceased from July 27 1929 to Aug 6 1929.

that I last saw him alive on Aug 6 1929

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chron. nephritis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & chemical

(Signed) L. M. C. Parker, M. D.

8/7, 19 29 (Address) 1114 Hennen Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 9 1929
20 UNDERTAKER	ADDRESS
Kenney Harrell Sons, Inc.	901 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48274 182 E 48274

1-PLACE OF DEATH Found floating in the water at

City of Baltimore: (No. Foot of Harner St. St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.(C)

(a) RESIDENCE NO. Do not know. St., 21-32 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found July 30, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probably accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Enquiry

(Signed) Otto M. Reinhardt, M. D.

8/6 . 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	Aug 6 1929
20 UNDERTAKER	ADDRESS
O. [illegible]	

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48275

CERTIFICATE OF DEATH

36-003

E 48275

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Graham Royston

(a) RESIDENCE NO. 557 Camel Alley ST., 17-24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Berry Royston

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed AUG 7 1929 UNIVERSITY OF MARYLAND HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to August 2, 1929, that I last saw him alive on August 2, 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous lymphadenitis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) Unknown yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab

(Signed) Jas E Arnold, M. D.

8-3-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

AUG 7 - 1929

Cor.—12-9-25—A Co.—200 Bks.

E 48276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48276

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. Calvert & 33rd St., Ward) 14-001 REGISTERED NO.

2-FULL NAME Robert D Hawkins 12-19

(a) RESIDENCE NO. Caroline Apt Wilmington N. Ca. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) ? 1873

7 AGE: Years 56; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Supervising Power

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Lafayette Ind.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Dr Glydson Brother in Law

(Address) Richmond Va.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) H. Gay Coroner, M. D.

, 1929 (Address) 3632 Portland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va. Date of Burial: Aug 7 1929

20 UNDERTAKER: Henry Hankins & Co ADDRESS: 1212 Pine St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

W01699

E 48277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1/3 E 48277

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 S. Baylis ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Katherine Dimick

(a) RESIDENCE NO. 904 S. Baylis ST., 26-1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10-1929

7 AGE — Years | Months | Days 26 | If LESS than 1 day, hrs. or min.

5 | 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John H Dimick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mollie Seibert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John H Dimick

(Address): 904 S Bayles St

15 Filed ..., 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6-1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929, to Aug 6, 1929, that I last saw her alive on Aug 5, 1929 and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

—

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [signature]

8/0, 1929 (Address) 10 W S. Edmondson Ave, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Aug 8 1929

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Aliceanna

Spec.—2-29-28—L. F. S.—500 Bks.

E 48278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 48278

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., WARD)

2—FULL NAME Elmer ~~Woolery~~ Woolery 6-11

(a) RESIDENCE NO. 3118 E. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of Elizabeth Woolery

6 DATE OF BIRTH (month, day, and year) March 27/1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Milk route

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Elijah Woolery

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. Crabtree

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed AUG 7 1929 C. HUBERT JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/29

17 I HEREBY CERTIFY, That I attended deceased from 8/5, 1929, to 8/7, 1929,
that I last saw h alive on 8/6, 1929
and that death occurred, on the date stated above, at 12 o. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Epiglottis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Lungs

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. C. Humphries, M. D.

8/9, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mem Cathedral — DATE OF BURIAL Aug 9 1929

20 UNDERTAKER John Ulrich — ADDRESS 2008 Adams

Cor.—10-10-29—A Co.—100 Bks.

E 48279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 48279

1-PLACE OF DEATH

City of Baltimore: (No. 1034 N. Stricker St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Parker Stratton

(a) RESIDENCE NO. 1034 N. Stricker St. Ward 16-22

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Stratton

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor.
(b) General nature of industry, business, or establishment in which employed (or employer) 210
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Geo Stratton

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Alice Upshur

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Julia Stratton
(Address) 1034 N. Stricker

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Morbid Condition)

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Smith, M. D.

(Address) Aug 6 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 1929
20 UNDERTAKER	ADDRESS
Sam'l W Cause & Son	100 Myrtle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HARRISON JONES, INC.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48280

CERTIFICATE OF DEATH

X 166

E 48280

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St., Ward)

2-FULL NAME Nancy Green.

(a) RESIDENCE NO. Barton, Md. St., 4-7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	35	-------	-------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Barton, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER
Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Mercy Hospital Report.
(Address)

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1929 192

17 I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Pneumonia.
Stricture of the Oesophagus. Swallowing of Lye with Suicidal Intent.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Barton, Md. June 20/29

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Hospital report.

(Signed) Otto M Steinhardt, M. D.

8/6, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	AUG 7 1929
20 UNDERTAKER	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48281 ✓ 90 E 48281

CERTIFICATE OF DEATH

1—PLACE OF DEATH Home for Incurables

REGISTERED NO.

CITY OF BALTIMORE: (No. 40th St & Cedar Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Stinchcomb

(a) RESIDENCE NO. 5508 Reisterstown Road ST. 24-B WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George Stinchcomb

6 DATE OF BIRTH (month, day, and year) May 30. 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John (?) Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Baden (State or country) Germany Baden

14 Informant George Stinchcomb (Address) 4714 Pimlico Road

15 Filed 7-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6. 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 17 , 1929, to Aug. 6 , 1929, that I last saw her alive on Aug. 6 , 1929 and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Edema

t 2 (duration) yrs. mos. 2[illegible] ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) H. S. Willis, M. D.

, 19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 9 1929

20 UNDERTAKER Mr. & Mrs. John W. Engel & Son 841 W. Fayette St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 48282

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48282

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Carroll ST., WARD) 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmira Bell

(a) RESIDENCE NO. 1143 Carroll ST., 21-29 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Bell

6 DATE OF BIRTH (month, day, and year) June 20, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Thomas Flayhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Flayhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Charles A. Bell

(Address) 1122 Cleveland St

15 Filed 7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 19 29 to Aug 5, 19 29,

that I last saw h alive on Aug 5, 19 29

and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Cancer

(duration) 2 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

Aug 6, 19 29 (Address) 515 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 8 1929

20 UNDERTAKER Mr & Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 48283

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1824 Wilkins Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Miller

(a) RESIDENCE NO. 1824 Wilkins Ave. ST., 19-28 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Miller

6 DATE OF BIRTH (month, day, and year) Aug. 18th. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Isaac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Aaron Miller

(Address) 1824 Wilkins Ave.

15 Filed 8/7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Aug. 6, 1929, that I last saw h alive on Aug 6. 1929 and that death occurred, on the date stated above, at 6.30 P. A.m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no. —

What test confirmed diagnosis? Typical Chan Etc.

(Signed) C. Hampson Jones, M. D.

8/9/ 1929 (Address) 888 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	8/8/ 1929
20 UNDERTAKER Ward Sondheim	ADDRESS 118 20 W. Mt. Royal Ave.

Cor.—10-10-29—A Co.—100 Bks.

E 48284

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48284

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 19 N. Smallwood St., Ward) 20-69

2-FULL NAME Mary Brown

(a) RESIDENCE NO. 19 N Smallwood St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or rountry) Md

PARENTS

10 NAME OF FATHER Michael Thomas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John E Brown
(Address)

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brosius M. D.

Aug 7. 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 9 29
UNDERTAKER Engel & Sulzer	ADDRESS Baltimore Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48285

CERTIFICATE OF DEATH

31

E 48285

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 223 S Hilton ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse Valentine

(a) RESIDENCE NO. 223 S. Hilton ST. 20 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Valentine

6 DATE OF BIRTH (month, day, and year) Aug 23, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22.	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER James H. Valentine

11 BIRTHPLACE OF FATHER (city or town) Penna

(State or country)

12 MAIDEN NAME OF MOTHER Emma Conner

13 BIRTHPLACE OF MOTHER (city or town) Virginia

(State or country)

14 Informant Mrs. Viola Valentine

(Address) 223 S Hilton St

15 Filed 7-1929, 19 C. HAMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1929, to Aug 6, 1929, that I last saw h[illegible] alive on Aug 5, 1929 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings, X-ray

(Signed) Edw. W. Berg M. D.

19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 8 1929
20 UNDERTAKER	**ADDRESS**
D Wm Cook	1217 St Paul St

E 48286

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48286

CERTIFICATE OF DEATH. 167-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 924 W Baltimore St WARD) REGISTERED No. C

2-FULL NAME Mary Treacy 18-26

(Residence in Baltimore: No. 924 W Baltimore St St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (*Write* the word.) Widowed

6-DATE OF BIRTH, ... (Month) — (Day) — (Year) 1906

7-AGE. 73 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Edw Burkhart

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Linda Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice Allen

(Address) 939 W Balto St

15-

Filed ..... 7 - 1929 ..... 19..... C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Aug (Day) 5 (Year) 1929

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Coroner, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gas Poisoning Self.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prolapsed

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner.)

..... 191... (Address) 1437 N Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem — DATE OF BURIAL, 8/8, 1929

20-UNDERTAKER C. F. Kahey Sons — ADDRESS 318 Eight St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

135 E 48287

REGISTERED NO. 2958

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Winfield J. Taylor 53

(a) RESIDENCE NO. 102 Park Lane ST., 27 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 2 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Winfield J. Taylor

6 DATE OF BIRTH (month, day, and year) May 13, 1850

7 AGE	Years	Months	Days 24	If LESS than 1 day, ...hrs. or ....min.
	79	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. R. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Georgiana Milligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Heiward Taylor

(Address) 102 Park Lane Roland Park

15 Filed AUG -1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to Aug. 7, 1929

that I last saw him alive on Aug 7, 1929, 19

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy.

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Prostatectomy.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 7-31-29

Was there an autopsy? Yes.

What test confirmed diagnosis? Pathology

(Signed) A. R. Wilkerson, M. D.

(Address) U. M. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Waverly	Aug 8 1929
20 UNDERTAKER	ADDRESS
Kenny & Jenkins Sons	McCulloh & Orchard Sts

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48288 1. PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St., WARD)

REGISTERED NO. E 48288

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Hartman

(a) RESIDENCE NO. North Point Creek 5 days. 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Todds Farm

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	M.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ John Hartman

6 DATE OF BIRTH (month, day, and year) Feb. 25 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5	11	10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Chestnut Ridge Md
(State or country)

PARENTS

10 NAME OF FATHER Nathan Gover.

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Martha Perry

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant John Hartman
(Address) North Point Creek Todds Farm Md

Filed Aug 8 1929 HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-31, 1929, to 8-5, 1929, that I last saw h[illegible] alive on 8-5, 1929, and that death occurred, on the date stated above, at 5:45 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary (Woman aged)

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Post-operative shock

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 3, 29

Was there an autopsy? —

What test confirmed diagnosis? Operation

(Signed) Emil Novak, M. D.

8/5, 1929 (Address) 26 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	aug 8 1929
20 UNDERTAKER	ADDRESS
Lilly & Gilmore	403 E. Mt. St.

IMPORTANT—See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Mary E Connolly ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48289

CERTIFICATE OF DEATH

129

E 48289

1—PLACE OF DEATH

REGISTERED NO. _____

CITY OF BALTIMORE: (No. 111 S. Linwood ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Connolly 1-2

(a) RESIDENCE NO. 111 S. Linwood ST., 1 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank J. Connolly

6 DATE OF BIRTH (month, day, and year) Dec. 29th 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER (Illegible) Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maria Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Frank J. Connolly

(Address) 111 S. Linwood Ave

15 Filed AUG 8 - 1929, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1929, to Aug 7th, 1929, that I last saw her alive on Aug 6, 1929, and that death occurred, on the date stated above, at 6 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Chronic Inter. Nephritis

Chronic Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav C. Rheins, M. D.

, 19 (Address) 16 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 10 1929
20 UNDERTAKER Lilly & Sons Inc.	ADDRESS 424 N. Howard St

Spec.—1-10-21—M&T—1500 Blks.

9106.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48290

CERTIFICATE OF DEATH.

161-001

E 48290

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 E Monument St. WARD) 7-9

2-FULL NAME Baby Antonia Grob

(a) RESIDENCE NO. 2003 E. Monument St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 7 How long in U. S., if of foreign birth? yrs. mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): July 31, 1929.

7 AGE: Years | Months | Days 6 | If LESS than 1 day, ... hrs. or .... min. 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John J. Grob

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Hedwig Esposito

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: John Grob (Address) 2003 E. Monument St

15 Filed AUG 8 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 6 - 29

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug 6 1929, that I last saw h[illegible] alive on August 6, 1929, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows: Gastritis due to Ch Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Antonio J. Valentine M.D.

(Address) 1K So Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Aug 8 1929

20 UNDERTAKER: William G. Schaffer — ADDRESS: 1816 Monument

IMPORTANT: See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

129 E 48291

E 48291

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. Jamison

(a) RESIDENCE NO. 620 N. Potomac ST., 7-11 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stable Boss

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 8/6

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Jamison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marg't McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record

(Address)

15 Filed AUG 9 - 1929 J. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/6/29

17 I HEREBY CERTIFY, That I attended deceased from 7/22, 1929, to 8/6, 1929, that I last saw him alive on 8/6, 1929 and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Gangrene Right foot
Chronic nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Crumpton, M. D.

8/6, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Aug 10 1929

20 UNDERTAKER Jos J Stevenson ADDRESS 126 Eugene

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48292

CERTIFICATE OF DEATH.

135 E 48292

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Kelly

(a) RESIDENCE NO. 1003 W. Lombard ST., 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mollie Kelly

6 DATE OF BIRTH (month, day, and year) Nov 6 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer B&O R.R.

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Forde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs James Murphy (Address) 1003 W Lombard St

15 Filed AUG 8 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1929 to Aug 7 1929.

that I last saw h/m alive on Aug 4 1929,

and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis with Uremic manifestations

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 4 1929

Was there an autopsy? No

What test confirmed diagnosis? clinical picture

(Signed) Arthur Kaltenmi M.D.

Aug 7, 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Giles Cem.	Aug 10th 29

20 UNDERTAKER John J Curran & Son ADDRESS Gonzaga

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-002 E 48293

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4714 Hampnett Ave. ST., WARD)

2-FULL NAME Edward S. Ege.

(a) RESIDENCE NO. 4714 Hampnett Ave. ST. 27-44 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? Life. yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 6 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

63

9 BIRTHPLACE (city or town) (State or country) Carlisle Pa.

PARENTS

10 NAME OF FATHER Peter F. Ege

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carlisle Pa.

12 MAIDEN NAME OF MOTHER Elisa A. Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carlisle Pa.

14 Informant Laura A. Mc. Guire

(Address) 4714 Hammett Ave.

15 Filed 8-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August, 7 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 1, 19 29, to Aug 7, 19 29, that I last saw h/m alive on Aug 7, 19 29, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Cerebral Palsy
Senility

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Herman A Voigt, M. D.

, 19 (Address) 5106 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 8/9 1929

20 UNDERTAKER: Leonard J. Ruck — ADDRESS: 6405 Seton Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48294

CERTIFICATE OF DEATH

74-001

E 48294

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3419 E. Lombard ST., 26 WARD)

2—FULL NAME Mary E. Hudnet (+6720 Germantown Rd.)

(a) RESIDENCE NO. 3419 E. Lombard St ST., 26-2 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4/0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Theodore Saint Hudnet

6 DATE OF BIRTH (month, day, and year): March 31 1854

7 AGE: Years 75 | Months 4 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): formerly housewife 037

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Charles Dooley

11 BIRTHPLACE OF FATHER (city or town) (State or country): not Known Sweeden

12 MAIDEN NAME OF MOTHER: Andersen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not Known Sweeden

14 Informant: Mrs. Anna Swanson (daughter)
(Address) 4620 Dorman Hill Rd. Balto Md.

15 Filed 8-1929 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug 7-29

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to Aug 7, 1929.
That I last saw h.r alive on Aug 6, 1929
and that death occurred, on the date stated above, at 1233 A.m.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Capillary Hemiti's

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What (est confirmed diagnosis?

(Signed) A. F. Wright, M. D.

8/8/, 1929 (Address) 1014 S. Edmond Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem

DATE OF BURIAL: aug 9 19 29

20 UNDERTAKER: Jack Lewis

ADDRESS: 1434 Eastern Ave

Col.—12-1-28—25,200 Bks.

E 48295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 188-001 E 48295

1-PLACE OF DEATH Md General Hospital

REGISTERED NO._____

City of BALTIMORE: (No._____ St.,_____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arbuth Helms

(a) RESIDENCE NO. Sparrows Point Md St. 11 Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 0 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1st 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33		6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroader

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) North Carolina

PARENTS

10 NAME OF FATHER John Helms

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Richmond Va

12 MAIDEN NAME OF MOTHER C. C. Helms

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Richmond

14 Informant Record of American

(Address) Legion Post no 88

15 FUNERAL_____ 19_____

8-1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an_____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Accidental Fractured Thigh + Fractured Pelvis (duration) mos. 21 ds. Caught between freight train (duration) mos. ds. Aug 8th 1929 (Coroner) M. D. (Address) Coroner,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va Date of Burial 8/8 1929

20 UNDERTAKER Robert Brooks & Son ADDRESS Calhoun & Hollins sts

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Alice Sitar

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48296

CERTIFICATE OF DEATH

32 ✓ E 48296

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Sitar.

(a) RESIDENCE NO. 4322 Fairhaven Ave ST. 25-77 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 15 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Sitari

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Bernadine Marko

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John Sitar

(Address) 4322 Fairhaven Ave

15 Filed AUG 8 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-7-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929, to Aug 7, 1929.

that I last saw her alive on Aug 7, 1929

and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis.

(duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary): Right Side Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) N B Kundrey, M. D.

(Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A C	8/9 1929
20 UNDERTAKER	ADDRESS
E & B Marks	1156 West St

Spec.—2-29-28—L. F. S.—500 Bks.

E 48297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48297

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4507 Wilmslow Road ST., WARD)

2—FULL NAME Mrs Sarah Brosnahan

(a) RESIDENCE NO. 4507 Wilmslow Rd. ST., WARD 27-53

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Brosnahan

6 DATE OF BIRTH (month, day, and year) ind com.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Nat.

9 BIRTHPLACE (city or town) Ind.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mr. Frank Brosnahan

(Address) 4507 Wilmslow Rd.

15 AUG 8 - 1929 SAMUEL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to Aug 7, 1929, that I last saw h alive on Aug 7, 1929 and that death occurred, on the date stated above, at 1:10 p. m.

The CAUSE OF DEATH* was as follows:

Cardio vascular disease.
Hypertension
Senile dementia.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw Toone, M. D.

19 (Address) 806 N Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Olivet Cem	Aug 10 1929
20 UNDERTAKER	ADDRESS
Ehrenworth & Son	Westwood

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48298

CERTIFICATE OF DEATH

E 48298

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1116 N. Fremont ~~St.~~ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Frances Stoffregen

(a) RESIDENCE NO. 1116 N. Fremont Ave. ST., 16-23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Ernst Stoffregen

6 DATE OF BIRTH (month, day, and year) Feb. 24 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George W. Edell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Emma O. Culver

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mother Mrs Emma Edell

(Address)

15 Filed G 8 - 1929, 19 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 - 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 19 29, to Aug 7, 19 29, that I last saw her alive on Aug 6, 19 29 and that death occurred, on the date stated above, at 11 45 p.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation heart (Chron)

10 Months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where did disease contracted if not at place of death? No

Did operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) H. W. Wheeler, M. D.

, 19 (Address) 1309 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Cem

DATE OF BURIAL 8/10 19 29

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hall

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48299

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. E 48299

1-PLACE OF DEATH

City of BALTIMORE: (No. 726 E. 20th St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Minton

(a) RESIDENCE NO. 726 E. 20th St. Ward 9-15

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 22nd 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	56	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Court Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Court of Co

(c) Name of employer Common Pleas.

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Patrick J. Minton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret M. Fahey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. M. McMahon

(Address) 726 E 20th St

15 Filed ..... 19 ..... CLAYTON JONES, M. D.

8-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 17th, 1929, to August 6th, 1929,

that I last saw him alive on August 6th, 1929,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Coma

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) 4 yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. Saunders, M. D.

8/6 1929 (Address) 729 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Cemetery 8/9/1929

20 UNDERTAKER ADDRESS

E. D. Fanning & Son 1938 E. Lafayette Ave.

Be sure to give full name, as that is the way it may be proved very important. See instructions on back of certificates. OF DEATH in preparing this

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48300

CERTIFICATE OF DEATH.

90

E 48300

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1141 Park Ave ST., - WARD)

2-FULL NAME Lee Stokes

(a) RESIDENCE NO. 1141 Park Ave ST., 11-24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Lillie Stokes

6 DATE OF BIRTH (month, day, and year) Aug 20, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Boomburg Va

PARENTS

10 NAME OF FATHER Stephen Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Boomburg Va

12 MAIDEN NAME OF MOTHER Julia Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Boomburg Va

14 Informant Lucy Smith

(Address) 1141 Park Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1929, to Aug 5, 1929, that I last saw h[illegible] alive on Aug 5, 1929, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos 2 mos ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Ellis, M. D.

8/6, 1929 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 8 1929
20 UNDERTAKER	ADDRESS 578 N Bridle
Samuel T Hensley	

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48301

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Laura Brown

(a) RESIDENCE NO. 328 W. Hoffman ST., 11-24 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865 ? Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) C 31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed G 8 - 1929, 19.. C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 3, 19 29, to August 7, 19 29

that I last saw her alive on August 7, 19 29

and that death occurred, on the date stated above, at 10:20 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute, Cerebral Thrombosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.E. Lab. X-ray

(Signed) Marvin M. McLean, M. D.

8-8, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	Aug 10 '29
20 UNDERTAKER Samuel J. Hendley	ADDRESS [illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

E 48302 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓

CERTIFICATE OF DEATH 123 E 48302

1—PLACE OF DEATH Univ. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Selander

(a) RESIDENCE NO. 1527 Poplar Grove ST., 16-68 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Married

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Anton Selander

6 DATE OF BIRTH (month, day, and year) 12/5/1876

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
52	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James Quinn

11 BIRTHPLACE OF FATHER (rity or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lucretia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or rountry) Baltimore

14 Informant Anton Selander

(Address) 1527 - Poplar Grove

15 Filed ..., 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-29

17

I HEREBY CERTIFY, That I attended deceased from 7/29/29, 19..., to 8/6/29, 19..., that I last saw her alive on 8/6/29, 19..., and that death occurred, on the date stated above, at 9:10 a.m.

The CAUSE OF DEATH* was as follows:

Postoperative shock

Post operative hemorrhage

from Liver following

Cholecystectomy (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Severe secondary anemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/5/29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Earl F. Lundbach, M. D.

, 19 (Address) University Hospital Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	8/9/29
20 UNDERTAKER	ADDRESS
George J. Roth	835 Hanover

Spec.—12-9-25—A Co.—200 Bks.

E 48303

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48303

CERTIFICATE OF DEATH.

129

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1602 Eutaw Place St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Brodie Clary

14-70

(a) RESIDENCE NO. 1602 Eutaw Place St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Buchanan

6 DATE OF BIRTH (month, day, and year) January 9th, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Henderson, N.C.

(State or country)

PARENTS

10 NAME OF FATHER Louis Brodie

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Thorp

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) North Carolina

14

Informant Edmund B. Clary

(Address) 235 E 68th St. New York

Filed Aug 8 1929 C. HAMPTON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1929.

17

I HEREBY CERTIFY, That I attended deceased from ..... 1919 to Aug. 7, 1929, that I last saw her alive on Aug. 7, 1929, and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia - 6 days -

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic - Nephritis -

(duration) 8 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? —

(Signed) Joseph W. Kelly, M. D.

, 19 (Address) 1207 Eutaw Place -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Henderson, N.C.

Date of Burial 8/9" 1929

20 UNDERTAKER Chas. Braune & Son

ADDRESS 1180 W. Mt. Royal Ave

Be sure to print plainly, so that it may be photographed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48304 ✓ E 48304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH X 44

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alfred Hawkins

(a) RESIDENCE NO. Frostburg, Md ST., 7-9 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or WIFE of) Clara

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Wm Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Anna Lynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Relative

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 8 - 1929 C. HAMPSON JONES, M. D. Registrar ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8/29

17 I HEREBY CERTIFY, That I attended deceased from July 2 . 1929. to August 8 . 1929.

that I last saw h/ alive on July 8 . 1929

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following gastrostomy for Carcinoma of esophagus.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of Aug 3, 1929

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Clarence Gardner Jr. M. D.

8/8 . 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md — DATE OF BURIAL 8/8/29

20 UNDERTAKER Joseph Abrens — ADDRESS 221 Bway

Spec.—2-29-28—L. F. S.—500 Blks.

E 48305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 48305

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME George Ashbey

(a) RESIDENCE NO. 2312 Druid Hill Ave. ST. 13-59 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henrietta Ashbey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Virginia

PARENTS

10 NAME OF FATHER Edward Ashbey

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Ann Savage

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Virginia

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 8-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 11, 19 29 to August 6, 19 29

that I last saw him alive on August 6, 19 29

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

Aortic insufficiency

Myocarditis Chronic Passive Congestion

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.C. Post. Lab Wad.

(Signed) Marvin M. McLean M. D.

8-7, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 8/9/29

20 UNDERTAKER Wm. Du H. Holland

ADDRESS 1613 Druid Park

Spec.—1-10-21—M & T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48306

CERTIFICATE OF DEATH.

49

E 48306

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3034 Greenmount Ave. WARD 14)

2-FULL NAME Ella a. Knight

(a) RESIDENCE NO. 3034 Greenmount Ave ST. 14 WARD 17-50

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10- 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... None

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Frank W Knight

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Louise Schuman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Mrs Geo Schuman
(Address) 3034 Greenmount Ave

15 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1929

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to Aug 3, 1929.

that I last saw he alive on Aug 3, 1929

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Sarcomatosis

about 6 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Removed & Exam Microscopically May 14 29

(Signed) Theodore Heise Jr. M. D.

8-8, 1929 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 9 1929

20 UNDERTAKER Mary M. Warfield

ADDRESS 501 E ~~Fayette~~

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH blank must be filled in. See instructions on back of certificates.
TION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48307

CERTIFICATE OF DEATH

185

E 48307

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lyons

(a) RESIDENCE NO. 908 N. Milton Ave ST., 7-1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., If foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ignatius

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 83 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Tabor Bohemia

PARENTS

10 NAME OF FATHER: Joseph Pojoucek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Katherine Staneb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Catherine Skarda

(Address) 908 N Milton Ave

15 Filed Aug 9 - 1929 19 ... J. P. ... W. Edgar Hoskins ... M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7/29

17

I HEREBY CERTIFY, That I attended deceased from 7-12-29, 19..., to 8-7, 1929.

that I last saw h.e.r. alive on 8-7- , 1929

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Fracture left femur

Acc Fall in dining room.

(duration) ... yrs. ... mos. 28 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Test

(Signed) J. B. Hendrix, M. D.

Bet Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Aug 10 1929

20 UNDERTAKER: Ernest Lauchson — ADDRESS: 1916 E Monument

Spec.—2-29-28—L. F. S.—500 Bks.

E 48308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 48308

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Yetta Benjamin

(a) RESIDENCE NO. 1700½ W Fayette ST., 9-27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Benjaman

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Coplin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Antown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eastern Ave

15 Filed G 9 - 1929 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1929

17

I HEREBY CERTIFY, That I attended deceased from August 2, 1929, to Aug 8, 1929, that I last saw her alive on Aug 8, 1929 and that death occurred, on the date stated above, at 12 20 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus.

(duration) yrs. 8+ mos. ds.

CONTRIBUTORY (Secondary) Pneumonia - terminal

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Oesophagoscopy - Biopsy Date of 8/7/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical - a

(Signed) J. A. Lyle, M. D.

8/8, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mah Rood	8/9th 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

227670 E 48309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 48309

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jerome Zolenas 25-72

(a) RESIDENCE NO. 1619 Spence ST., St — WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	child

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Anthony Zolenas

11 BIRTHPLACE OF FATHER (city or town) Md. — (State or country)

12 MAIDEN NAME OF MOTHER Ljel Sudderynes

13 BIRTHPLACE OF MOTHER (city or town) Md — (State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed G 9 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7-29

17 I HEREBY CERTIFY, That I attended deceased from July 31. 1929. to Aug 7. 1929.

that I last saw him alive on Aug 7 1929

and that death ocrurred, on the date stated above, at 3 25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism following Appendectomy.

9 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism (?)

9 days. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/30/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical course.

(Signed) Clarence C Gardner Jr. M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	aug. 10 1929
20 UNDERTAKER	ADDRESS
John Grebliauskas	1235 Lora

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48310 E 48310

CERTIFICATE OF DEATH. 148

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ~~1116~~ Mosher ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucille Morris 23

(a) RESIDENCE NO. 1116 Mosher ST., 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	15	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) md.

PARENTS

10 NAME OF FATHER Richard Morris.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margarete Walley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Margarete Morris
(Address) 1116 Mosher St

15 Filed AUG 9 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6th, 1929, to Aug. 7th, 1929, that I last saw her alive on Aug. 7th, 1929, and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

PREGNANCY
AND
Pre-eclamptic Toxaemia
(duration) yrs. 8½ mos ds.

CONTRIBUTORY (Secondary) Eclampsia
(duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death? 1116 Mosher St.

Did an operation precede death? Yes Date of Aug. 6th 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Manuel A. Nabors, M. D.

, 1929 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Aug 10 1929

20 UNDERTAKER Thomas E. Kelson. — ADDRESS 1503 Pennsylvania Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48311

CERTIFICATE OF DEATH.

129 E 48311

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1629 Presbury ST., ... WARD) 15-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aaron Whitlett

(a) RESIDENCE NO. 1629 Presbury ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida White

6 DATE OF BIRTH (month, day, and year) 6-19 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jerry White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Carrie W. Stewart

(Address) 1629 Presbury St.

15 Filed Aug 9 1929

C. HAMPSON JONES, M. D. Registrar

GS - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6— 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1929, to Aug. 6, 1929, that I last saw h in alive on 8-6—, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH was as follows:

Cardio-Renal-Vascular Disease

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) George A. Rogers, M.D.

, 19 (Address) 516 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 9 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Pressman

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48312

CERTIFICATE OF DEATH

3 | E 48312

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ludie Colston (Lutie R. Spencer Colston)

(a) RESIDENCE NO. 1129 N. Mount st. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER James Colston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Nellie Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to August 5, 1929,

that I last saw her alive on August 5, 1929

and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8-7, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlestown W Va	8/10 1929
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Paca

Cor.—10-10-29—A Co.—100 Blks.

48313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48313

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1723 Maryland Ave. St., Ward) 1220

2-FULL NAME John Logan.(C)

(a) RESIDENCE NO. 1723 Maryland Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, HUSBAND of (or WIFE of) Carrie Logan.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Cornelius Carter.(C)
(Address) 1723 Maryland Ave.

15 Filed AUG 9 - 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Reinhardt, M. D.

8/8 . 1929 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. F. Auburn Cem	8/9 1929
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 48314

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48314

CERTIFICATE OF DEATH

46

REGISTERED NO. 2697

1-PLACE OF DEATH

City of BALTIMORE: (No. 617 Greenwillow St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Neal

(a) RESIDENCE NO. 617 Greenwillow St 17-24 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE — Years — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Work 21

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) —

(State or country) md

12 MAIDEN NAME OF MOTHER — Unknown

13 BIRTHPLACE OF MOTHER (city or town) md

(State or country) —

14 Informant Nellie Nicholson

(Address) 617 Greenwillow St

15 Filed AUG 9 - 1929 HARRISON JONES M. D. Registrar

Per Neil

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-6-1929

Aug. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Aug 6, 1929,

that I last saw h[illegible] alive on Aug 6, 1929,

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Carcinoma of uterus

(duration) 2 yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical Tests

(Signed) N. Catnell Jones, M. D.

, 19 (Address) 1123 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt Auburn Cemetery — Date of Burial — Aug 9 1929

20 UNDERTAKER J Leon Hall — ADDRESS 75-3 Dolphin 21

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH D 48315 REGISTERED NO. D 48315

CITY OF BALTIMORE: (No. 534 n Bond ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin Thomas

(a) RESIDENCE NO. 534 n Bond ST. 28-11 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Thomas

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Efforts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Robt Thomas

(Address) 534 n Bond St

15 Filed 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6-29

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1929 to Aug 6, 1929, that I last saw h.. alive on Aug 6 1929 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Aguda Catarrah Pneumonia

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) George S. Keller M. D.

Aug 8, 1929 (Address) 508 Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	8 10 1929
20 UNDERTAKER	ADDRESS
Byrow Wright	1218 McCulloh St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48316

CERTIFICATE OF DEATH.

161-001 E 48316

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Weinstein

(a) RESIDENCE NO. 1210 Balto ST. E WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/7/29.

7 AGE Years Months Days If LESS than 1 day, 3 hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Isadore Weinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Belle Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland.

14 Informant (Address) Hospital Records.

15 Filed AUG 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/8 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1929, to Aug 8, 1929, that I last saw h[illegible] alive on Aug 8, 1929, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. F. Blum, M. D.

8/9, 1929 (Address) W Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring y Bur.

DATE OF BURIAL 8/9 1929

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

IMPORTANT—See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48317

CERTIFICATE OF DEATH

117

REGISTERED NO. E 48317

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33 29 & Calvert ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth M. Eastman (Mrs) 28.6

(a) RESIDENCE NO. 2516 Queen Anne ST., Road WARD Windsor Hills, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Dr Louis M. Eastman

6 DATE OF BIRTH (month, day, and year) May 31, 1871

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58 years	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of indostry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Hynes

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah E. Smith

13 BIRTHPLACE OF MOTHER (city or town) Catonsville (State or country) Maryland

14 Informant Dr. Louis M. Eastman (Address) 2516 Queen Anne Road

15 Filed AUG 3 - 1929 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/6/29, 19 27, to Aug 1, 19 29, that I last saw her alive on Aug 1, 1929 and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis, presumably caused by ruptured appendix. Appendectomy right lower extended.

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Carcinoma pancreas & left leg (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? While on motor trip

Did an operation precede death? Yes Date of 8/6/29

Was there an autopsy? No

What test confirmed diagnosis? Resuscitation to heart stopped

(Signed) James Arthur Greenberg M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy.	Aug. 10, 1929
20 UNDERTAKER	ADDRESS
Wm. C. Mitchell & Sons	1900 Eutaw Pl.

Spec.—2-29-28—L. F. S.—500 Bks.

RUPINSKI

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48318

CERTIFICATE OF DEATH

113 E 48318

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 Cambridge ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Rupinski Jr.

(a) RESIDENCE NO. 2222 Cambridge ST., 1-3 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 26-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Rupinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Kwiatkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant James Rupinski

(Address) 2222 Cambridge ave

15 Filed Aug 10 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1929, to Aug. 8, 1929, that I last saw him alive on Aug. 7, 1929 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis — Colitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) David Steinglass M. D.

8/8, 1929 (Address) 4007 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	8/10 1929.
20 UNDERTAKER	ADDRESS
George A Weber	705 E Baltimore

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48319 ✓ E 48319

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp. St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert B Green

(a) RESIDENCE NO. 2017 Division ST. 14-20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Green

6 DATE OF BIRTH (month, day, and year) Nov 14, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64	65	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex Co. (State or country) Va.

PARENTS

10 NAME OF FATHER General Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Son

(Address)

15 Filed 9-1929 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1929

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to Aug 6, 1929.

that I last saw h(im) alive on Aug 6, 1929,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) George McDonald, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 9 1929
UNDERTAKER Wm. G. A. Elbert	ADDRESS 1925 Eastlandave

FROM EVERY HOSPITAL See instructions on back

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48320

188-006

REGISTERED NO. E 48320

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: Winchester + Woodyear (No.) (Ward)

2-FULL NAME Joseph Volpe

(a) RESIDENCE NO. 914 Stiles St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Rosalea Volpe

6 DATE OF BIRTH (month, day, and year) Nov 8 - 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54	8	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Water Dept
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Anthony Volpe

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Frances Cincotti

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Nicholas Spinato
(Address) 1905 Gough

15 Filed Aug 9 - 1929 HAMILTON JONES, Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 7th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental

Fractured Ribs & Suffocation

(duration) Sudden

CONTRIBUTORY (Secondary) Cave in

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Winchester + Woodyear

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Aug 7th Herbert Koehler, M. D.

(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 10 1929

20 UNDERTAKER Frank V. Pupitone

ADDRESS 2818 E. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48321

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48321

CERTIFICATE OF DEATH

92

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St., Ward)

2-FULL NAME Charles E. Dickerson.

(a) RESIDENCE NO. 5810 Morello Rd. St., 27-44 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, XXXXXXXXXXX HUSBAND of XXXXXXXXX Marion Dickerson.

6 DATE OF BIRTH (month, day, and year) June 12 1878

7 AGE	Years	Months	Days 76	IF LESS than 1 day ....hrs. or ....min.
	51	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stationary Engineer. 30
(b) General nature of industry, business, or establishment in which employed (or employer) Horn's Ice Cream Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Burdine Dickerson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER
-------Sowers.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Joseph Dickerson.(son)
(Address) 2311 Greenmount Ave.

15 Filed 9 - 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 446 Gisquith St. August 8, 1929

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Eminardt M. D.

8/8 . 1929 (Address) 1017 E. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 12 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 E. Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 48322 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 48322

CERTIFICATE OF DEATH. 33

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Margaret Reichert

(a) RESIDENCE No. 1236 North Gay ST., 8 1 3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? ~~Life~~ mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	7	4 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Philip Reichert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Geiger (Reba)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Frederick A. Reichert

(Address) 1 Willow Ave Overlea Md.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

9-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to Aug 8, 1929, that I last saw her alive on Aug 8, 1929, and that death occurred, on the date stated above, at 5.45 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Aug-6-29

Was there an autopsy? yes

What test confirmed diagnosis? path exam

(Signed) Dale P. Clinton M. D.

(Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL 8/10 1929

20 UNDERTAKER Wellman Cook ADDRESS 1211 Cathedral

CAUSE OF DEATH. ATTENTION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 E 48323

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St., Ward)

2-FULL NAME James J Seaton

(a) RESIDENCE NO. 918 S. Lehigh St., 26-37 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Seaton

6 DATE OF BIRTH (month, day, and year) Mar. 31-1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	—	4	—

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) Bang & Chem Co
(c) Name of employer Robbins Co Balto Md

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Jas Seaton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Stanton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Minnie J Seaton
(Address) 918 S Lehigh St

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

9-1929 By ....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract. Comp. Comm. L. Leg.
Run over by auto truck while in his position as watchman (duration) 4 yrs. 7 mos. da.

CONTRIBUTORY (Secondary) Hemorrhage & Traumatic Shock (duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? Clinton St (Ford)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Braun M. D.

8. 19 9 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Aug 9 1929

20 UNDERTAKER Rendall & Hyppd and Sedan ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 48324

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48324

CERTIFICATE OF DEATH. 167-001

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No.

2-FULL NAME Minnie E Eason

(a) RESIDENCE NO. 4405 Forrest View Ave 27-44 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence E Eason

6 DATE OF BIRTH (month, day, and year) Aug 11 1883

7 AGE: Years 45 Months 11 Days 26 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Lakeshore Md

PARENTS

10 NAME OF FATHER George A.T. Jubb

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Anna Arundel Co

12 MAIDEN NAME OF MOTHER Josephine Linstead

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Anna Arundel Co

14 Informant Mr Clarence E Eason

(Address) 4405 Forrest Ave

Filed 1929 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gas Poisoning Self

(Duration) ... yrs. ... mos. — ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ... yrs. ... mos. 6 hrs

(Signed) G C Blades M. D.

(Coroner)

8/29, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial Aug 9 1929

20 UNDERTAKER John F Denny ADDRESS 515 E Lexington St

Of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48325

CERTIFICATE OF DEATH

188-006 E 48325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: Woodyear & Winchester Ward)

2-FULL NAME Nicholas Zito.

(a) RESIDENCE NO 206 N. Eden St., 10-14 Ward
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jennie Dillaria

6 DATE OF BIRTH (month, day, and year) Nov 6-1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	56	9	1	

8 OCCUPATION OF DECEASED
(a) Trade, professinn or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Water Dept
(c) Name of employer City

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Pellegrino Zito.

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mckenna

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Jennie Zito
(Address) 206 N. Eden

15 Filed ..... H. HAMILTON JONES, M. D., City Registrar
By .....

AUG 9 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7th 192 9

I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

Accident
Fractured Skull &
Suffocation
(duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary) Cave in.
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted? If not at place of death? Cave in Winchester & Woodyear

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) J. B. Funk, M. D.

Aug 7th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	8/10 1929
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Milford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

48326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 48326

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1016 N. Vincent St., WARD)

2—FULL NAME Elizabeth Jackson

(a) RESIDENCE NO. 1016 N. Vincent ST., 16-27 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 2-1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid. 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Flemington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lena Williams

(Address) 1016 N. Vincent

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

UG 5 -

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 6th, 1929, to Aug 7, 1929, that I last saw h alive on Aug 7, 1929, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy.) (duration) yrs. mos. 1/2 hr.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Aug 8th C. Hampson Jones, M. D.
(Address) 1016 N. Vincent St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 10 1929
20 UNDERTAKER Virginia A. Brooks	ADDRESS 1403 W. Lanvale St

Spec.—2-29-28—L. F. S.—500 Bks.

E 48327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48327

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 1307 N. Montford Ave ST., WARD) 8-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph A. Mathieu

(a) RESIDENCE NO. 1307 N. Montford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 9 mos. 7 ds. How long in U. S., If foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

.a If married, widowed, or divorced HUSBAND of (or WIFE of) Augusta Mathieu

6 DATE OF BIRTH (month, day, and year) Nov. 1st 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 071

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Agent

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Mathieu

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Girard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Augusta Mathieu

(Address) 1307 N. Montford Ave

15 Filed 6 DEC [illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1929

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to Aug 8, 1929, that I last saw him alive on Aug 6, 1929 and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. O. Hergogmd M. D.

8/8, 1929 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 10 1929
20 UNDERTAKER	ADDRESS
Henry Hoelck Sons Inc.	1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48328

CERTIFICATE OF DEATH

16-002 V

E 48328

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 N Kenwood Ave STREET) (WARD) 7-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Myrna Webb

(a) RESIDENCE NO. 510 N Kenwood Ave STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 29 1929

7 AGE	Years	Months	Days 9	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER William Robb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elvira Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Father

(Address) 510 N Kenwood Ave

15 Filed AUG 9 1929 H. JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1929, to Aug 9, 1929, that I last saw h.er alive on Aug 8, 1929 and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Dysentery Bacillary

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Horace B. Tillett, M. D.

Aug 9, 1929 (Address) 515 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartes Sec	Aug 9 1929
20 UNDERTAKER	ADDRESS
M. W. & Dyer Co	32 Lamb

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48329

CERTIFICATE OF DEATH.

113 E 48329

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. (No. 1332 N. Gilmor St. WARD) 5/22

2-FULL NAME Mary Thomas

(a) RESIDENCE NO. 1332 N. Gilmor St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 28 1929

7 AGE Years Months 4 Days 8 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Leo Joyce

11 BIRTHPLACE OF FATHER (city or town) Ohio (State or country)

12 MAIDEN NAME OF MOTHER Carrie Thomas

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Carrie Thomas (Address) 1332 N. Gilmor

15 Filed ..., 19... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1929

I HEREBY CERTIFY, That I attended deceased from Aug 7, 1929, to Aug 8, 1929, that I last saw h[illegible] alive on Aug 8, 1929, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Toxemia.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No · Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Geo. E. Shannon, M. D.

5/9. 1929 (Address) 700 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cypress Co. Md. Cypressburg DATE OF BURIAL Aug 10 1929

20 UNDERTAKER Thomas E. Mushett ADDRESS 864 Mary

IT IS very important. See instructions on back.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48330

CERTIFICATE OF DEATH

90 E 48330

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Samuel Myers

(a) RESIDENCE NO. 16 N. Frederick ST., 4-7 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Degan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of
(Address) Baltimore City Hospitals

15 FILED AUG 9 - 1929 [illegible] JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 4, 1929 to August 8, 1929

that I last saw him alive on August 8, 1929

and that death occurred, on the date stated above, at 3:40 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Arteria Facialis Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Marvin M. McLean, M. D.

8-9, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] Pine Grove Cemetery	AUG 10 1929
20 UNDERTAKER Conrad to Lno W. O. Fiss	ADDRESS Pennsylvania Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 48331 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 48331

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Isaiah Russell

(a) RESIDENCE NO. 925 Shields Place ST., 17-24 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Russell

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Maryland

PARENTS

10 NAME OF FATHER: Robert Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Virginia

12 MAIDEN NAME OF MOTHER: Phyllis Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Virginia

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed ..... 19 ..... C. HAMILTON JONES ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1929 to August 6, 1929 that I last saw h... alive on August 6, 1929 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Thrombo-endocarditis, chronic & recent Hemiplegia, left, (Hemorrhagic?)

(duration) ? yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) — yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.E.

(Signed) Harris W. McClain, M. D.

8-7, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 8 1929
20 UNDERTAKER	ADDRESS 3224
Mrs. Katie R Williams	Johnson St

8-10-1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 48332 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 48332

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 E 29th ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline H Lanster

(a) RESIDENCE NO. 1832 E 29th ST. 9-46 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 16th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	51	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner 186

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER J George Lanster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bertha F Pfeffenbinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Bertha F Lanster

(Address) 1832 E 29th st

15 Filed AUG 9 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8th 1929

17

I HEREBY CERTIFY, That I attended deceased from March, 1928, to Aug 8, 1929, that I last saw h[illegible] alive on Aug 7th 1929 and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver (primary

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of about Thurs 1st May

Was there an autopsy? No.

What test confirmed diagnosis? Laparotomy

(Signed) Chas. O. Lorenz M. D.

5/5/29 (Address) 9 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 10th 1929
20 UNDERTAKER	ADDRESS
George Schulting & Sons	1136 Hanover St

Important: Be sure that every item is correctly answered.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48333

CERTIFICATE OF DEATH.

90 E 48333

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Kane

(a) RESIDENCE NO. 1512 E. Fort Ave 24-35 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Archibald Kane

6 DATE OF BIRTH (month, day, and year) March 4. 1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Fertilizing Co

(b) General nature of industry, business, or establishment in which employed (or employer) Armour's

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. Kane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Ella G. Kane

(Address) 1512 E. Fort ave.

15 Filed 9-1929 . 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/30 . 1929 to 8/7 . 1929 that I last saw h alive on 8/7 . 1929 and that death occurred, on the date stated above, at 11:20 a m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
arteriosclerosis & hypertension

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Theo. E. Stacy M. D.

. 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	aug 10 1929
20 UNDERTAKER Margaret L. Flynn	ADDRESS 1722 Light

CAUSE OF DEATH should be filled in by physician. Please write plainly with pen and ink. See back of certificates.

IMPORTANT is very important. See instructions on back

Spec.—2-29-28—L. F. S.—500 Blks.

Keefe

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48334

CERTIFICATE OF DEATH

31 E 48334

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cornelius Keefe

(a) RESIDENCE NO. Baltimore City Hospitals ST., 26-37 WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER Timothy Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Calaheler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address)

15 8-9-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1928, to August 3, 1929, that I last saw him alive on August 3, 1929 and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Chas Garner, M. D.

8-3, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 8-9-1929

20 UNDERTAKER J J Treacy & Sons

ADDRESS 1318 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 48335

CERTIFICATE OF DEATH 188-002

E 48335

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Guilford & North Aves. St., Ward)

2-FULL NAME Howard Watkins.(C)

(a) RESIDENCE NO. 1718 Latrobe St. St., 12-19 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, ~~Widowed~~ HUSBAND of (~~or WIFE of~~) ~~XXXXXXX~~ Maggie Watkins.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	39	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) O.H.B.
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Harrold Watkins.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Lucy.-------(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Maggie Watkins.(C) wife.
(Address) 1718 Latrobe St.

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar
9-1929 By ---

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed about the body, struck and knocked down by a street car.
Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto W. Leinhardt, M. D.

8/8, 1929 (Address) 101 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dunville, Va.	8/10/1929
20 UNDERTAKER	ADDRESS
Mrs Geo. H. Holland	1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48336 ~~E 27887~~ X 49 E 48336

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr & May Jacob C Bowman

(a) RESIDENCE NO. Washington D.C. ST., 7-9 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S. if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Alma Bowman

6 DATE OF BIRTH (month, day, and year) 1-1-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John. W. Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Car

12 MAIDEN NAME OF MOTHER Sarah C Prather

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 9-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August-9-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1929, to Aug 9, 1929, that I last saw him alive on August-9, 1929 and that death occurred, on the date stated above, at 6 ~~P~~ A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate invading Bladder and rectum.

Uraemia (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 9 ds.

18 Where was disease contracted ? if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Amputation of organ

(Signed) Harry G. Bollenberger, M. D.

8/9, 1929 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winston-Salem N.C.	Aug 9 1929
20 UNDERTAKER	ADDRESS
Hughes & Jones Inc	424 N Main

Spec.—2-29-28—L. F. S.—500 Blks.

E 48337

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 48337

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 323 S. Eden St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Celano

(a) RESIDENCE NO. 323 S Eden St ST., 3-4 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6 DATE OF BIRTH (month, day, and year) November 1904

7 AGE Years.	Months	Days	If LESS than 1 day, hrs. or min.
24.	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Domenick Frick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Angelina Di Fiore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Angelina Celano
(Address) 323 S Eden St

15 Filed 8-1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 19 29, to Aug 7, 19 29, that I last saw her alive on Aug. 7, 19 29 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum, X-ray

(Signed) Eugene L. Pessano, M. D.

Aug. 8, 19 29 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 10. 1929.
20 UNDERTAKER Wendell J. Hoppel	ADDRESS 300 N Eden St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48338

CERTIFICATE OF DEATH

129 E 48338

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2623 Dulaney St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME STRAUB. Sarah Dembinsky

(a) RESIDENCE NO. 2623 Dulaney St. ST., 20 69 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late John Dembinsky

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, bosiness, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Gumpman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William J. Snyder

(Address) 512 East Lynn St.

15 Filed 9-1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25th, 1929, to Aug 7th, 1929.

that I last saw her alive on Aug 7th, 1929

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy
Chr. Nephritis
Arterio Sclerosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion of Lungs (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Lewis Mowell, M. D.

19 (Address) 715 Frederick Ave. Catons.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	8/10/29

20 UNDERTAKER Harry N. Witzke, 1531 W Lombard St. ADDRESS

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48339

CERTIFICATE OF DEATH

11 E 48339

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland General Hospital 42-50 WARD)

2—FULL NAME Alfred Kimball

(a) RESIDENCE NO. 332 Chelsea Ave ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White Caucasian	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kimball

6 DATE OF BIRTH (month, day, and year) Sept 20, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postal Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Harford County Maryland

PARENTS

10 NAME OF FATHER Franklin W. Kimball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County Md.

12 MAIDEN NAME OF MOTHER Rose Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford County Md.

14 Informant Hospital Records
(Address)

15 Filed 10 1929 C. HAMPSON JONES, M. D. Registrar

Important. See instructions for date of certificate

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1921

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1921, to Aug. 1, 1921, that I last saw h.. alive on Aug. 1, 1921 and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis -
Peritonitis Gangrenous

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug. 4, 1921

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. McKaig Statham, M. D.

(Address) 1 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt Zion Hoopd. Co	Oct 10 1929
20 UNDERTAKER	ADDRESS
Herbert Bailey	Darlington Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 48340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48340

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1148 W. Hamburg ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Peter Wisenauer

(a) RESIDENCE NO. 1148 W. Hamburg ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Wisenauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margaret Wuest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Margaret Wisenauer

(Address) 1148 W. Hamburg St.

15 Aug 9 1929 C. HAMPSON JONES, Registrar M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1929. to Aug 8. 1929.

that I last saw him alive on. on Aug 7 1929

and that death occurred, on the date stated above, at 5.55 p.m.

The CAUSE OF DEATH* was as follows:

[redacted] Hearts Disease

Valvular Hearts Disease

—

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? clinical

(Signed) John F. Denny M. D.

8/9 1929 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 12 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48341

CERTIFICATE OF DEATH

112 E 48341

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 753 W Franklin St. Ward) 17-26

2-FULL NAME George Stanley

(a) RESIDENCE NO. 753 W Franklin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Stanley

6 DATE OF BIRTH (month, day, and year) — 1886

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
43	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Frank Stanley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Jane Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mary Stanley
(Address) 753 W Franklin

15 Filed ..., 19.. C. HAMPSON JONES, M. Registrar

AUG 10 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Tuberculosis

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Tb Cardiac Dil

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

What test confirmed diagnosis? History

(Signed) H. G. Gladis, M. D.

(Address) 1378 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8/12 1929
20 UNDERTAKER	ADDRESS
Samuel Easton	916 Pacific

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48342

CERTIFICATE OF DEATH

138 E 48342

1—PLACE OF DEATH Balto. City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Mason

(a) RESIDENCE NO. 1108 Shields Alley WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Wm. Mason

6 DATE OF BIRTH (month, day and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country) Maryland.

PARENTS

10 NAME OF FATHER Geo. Courtney

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Druzella

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Maryland.

14 Informant William Mason

(Address) 1108 Shields

15 Filed 10 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/29

17 I HEREBY CERTIFY, That I attended deceased from 7/15 , 1929, to 8/9 , 1929, that I last saw her alive on 8/9 , 1929 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Syphilis Meningitis

(duration) Unknown

CONTRIBUTORY (Secondary) Pulmonic Stenosis (duration) Unknown

18 Where was disease contracted If not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture

(Signed) Fred W. Duckwall, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	8/12 '29
20 UNDERTAKER	ADDRESS
Daniel Easter	916 Pa Ave

Spec.—1-12-23—M&T—500 Bks.

E 48343

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48343

CERTIFICATE OF DEATH.

1929

1-PLACE OF DEATH Good Shepherd Hospital

REGISTERED NO. 1-726

CITY OF BALTIMORE: (No. 1512 N. Gilmore ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Fisher

(a) RESIDENCE NO. 720 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of: Jacob Fisher

6 DATE OF BIRTH (month, day, and year): July 28, 1877

7 AGE: Years 52; Months; Days 10; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 070

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: Mrs. A. Schuchhardt

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Joduis Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fayette N.C.

12 MAIDEN NAME OF MOTHER: Rachel Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co. Md.

14 Informant: Ellen Fisher (Address): 1422 Madison Av.

15 Filed 10 1929, 19 C. HAMPSON JONES, M. Registrar. By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/8/1929

17

I HEREBY CERTIFY, That I attended deceased from 7/27/, 1929, to 8/8/, 1929.

that I last saw h[illegible] alive on 8/8/, 1929.

and that death occurred, on the date stated above at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Hopeless, Hemoplegia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr. Arteriosclerosis Nephritis

(duration) yrs. 8 mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical History

(Signed) W. Hall Emerson, M. D.

, 19 (Address) 720 Pierce St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lot. Auburn Cemetery — DATE OF BURIAL: Aug 12, 29

20 UNDERTAKER: John H. Johnson — ADDRESS: 2325 Madison Av

FROM is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 48344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33

E 48344

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1233 Division St. (WARD) 19-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Earl Boyd

(a) RESIDENCE NO. 1233 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/31/1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lula Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Martha Hopkins
(Address) 1233 Division St

15 Filed 8 7 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/1929

17 I HEREBY CERTIFY, That I attended deceased from 7/30/1929 to 8/7/1929

that I last saw 14 alive on 8/7/1929

and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Brain

(Duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) Tuberculosis of Pulmonary (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Clark, M. D.

, 1929 (Address) 924 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Aug 10 29

20 UNDERTAKER Samuel Hemsley ADDRESS 1300 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48345 — 002 — 161 — E 48345

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Mc Dougall

(a) RESIDENCE NO. 1245 High Alley ST., _____ WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	black	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/31/29 unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9 do	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in whirh employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Ossie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 10 1929 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 29

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929 to Aug 8, 1929

that I last saw h e alive on Aug 8 1929

and that death occurred, on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Disease

Intra cranial Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) E. K. Campbell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery — DATE OF BURIAL aug 12 19 29

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48346

91-09 E 48346

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3312 Fleet St. ST. 26-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A Hemminger

(a) RESIDENCE NO. 3312 Fleet St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mr H Hemminger.

6 DATE OF BIRTH (month, day, and year) April 28-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Michael Trentlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Link

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wilhelmina A Bigemer

(Address) 1018 Patterson Pk Ave

15 Filed 10 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9" 1929

17

I HEREBY CERTIFY, That I attended deceased from April 16" 1929, to August 9" 1929, that I last saw her alive on August 9" 1929 and that death occurred, on the date stated above, at 2 35 P m.

The CAUSE OF DEATH* was as follows:

General Arterial Sclerosis

(duration) yrs. 3 mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb W. Athey, M. D.

Aug. 9" 1929 (Address) 100 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Aug 12 1929
20 UNDERTAKER H Mc Cook	ADDRESS 1211 E Baltimore

Spec.—12-9-25—A Co.—200 Bks.

E 48347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 E 48347

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1040 N. Franklin St. (Ward) 1826

2-FULL NAME Annie E. Courcey

(a) RESIDENCE NO. 1040 N. Franklin St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William De Courcey

6 DATE OF BIRTH (month, day, and year) June 10, 1885

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
44	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER Wm. Taylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Fairer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant (Address) Mrs. Annie E. Courcey 1040 N. Franklin St.

15 Filed ..... 1929 C. HAMPSON JONES, M. D. Registrar

10 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/29

17 I HEREBY CERTIFY, That I attended deceased from July 16 1929, to Aug 7, 1929

that I last saw h.E. alive on Aug 6, 1929

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) acute Nephritis

(duration) yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) John F. Compton, M. D.

, 19 (Address) 1212 N. Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lem Cemetery Date of Burial Aug 10, 1929

20 UNDERTAKER Mrs Katie R W Adams ADDRESS 322 Schroeder

very important. See instructions on back of certificates.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

E 48348

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 9 1 48348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 908 N. Eutaw St. 11-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emerson G. C. Mifall

(a) RESIDENCE NO. 908 N. Eutaw St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto. Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Repairing Cars

(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co
(State or country) Md.

PARENTS

10 NAME OF FATHER Clinton Mifall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Somerset Co Md

12 MAIDEN NAME OF MOTHER Sallie Roberts

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Somerset Co Md.

14 Informant Mrs. Douglass
(Address) 908 N Eutaw St

15 Filed 10 1929 C. HAMPSON JONES, M. D. Registrar

By RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1929, to Aug 8, 1929.

that I last saw h alive on Aug 8, 1929.

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs mos 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Newark N. J

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. H. Wright, M. D.

(Address) 1209 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Co. records — DATE OF BURIAL: 8/11 1929

20 UNDERTAKER: Chas. H. Glenn — ADDRESS 1406 Druid Hill Ave

THIS is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48349 E 48349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 Linwood St 11-6-67 WARD) REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Florence Basil

(a) RESIDENCE. NO. 730 Linwood St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas P. Basil

6 DATE OF BIRTH (month, day, and year) June 8, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER N. H. Harman

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Rosina V. Kyches

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr Nicholas P. Basil
(Address) 730 Linwood St

15 Filed . 19 Registrar

G 10 1929 C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1925, to Aug 9, 1929, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Sol. Wissig, M. D.

. 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Bluff Annapolis Co	Aug 11 1929

20 UNDERTAKER B L Hopkins ADDRESS Annapolis Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 48350 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 W Conway ST. 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jerome Walker

(a) RESIDENCE No. 618 W Conway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec-18-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James A Walker

11 BIRTHPLACE OF FATHER (city or town) Asheville (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Helen Pearson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant James A Walker (Address) 618 W Conway

15 Filed 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-9 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug-5. 1929. to Aug-9. 1929.

that I last saw him alive on Aug 8 1929.

and that death occurred, on the date stated above, at 8-30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) — yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Diagnosed before death by symptoms

(Signed) David Grauman, M. D.

8/9, 1929 (Address) 122 W Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL 8/10 1929

20 UNDERTAKER Walter E. Sprigg Sr.

ADDRESS 1240 Hanlay St.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48351

CERTIFICATE OF DEATH

X 41

E 48351

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter Schmidt

(a) RESIDENCE NO. Gambrills, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 360 ds. How long in U. S., If foreign birth 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Caretaker at

(c) Name of employer U.S.N.A. Farm.

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Andrew Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant A. Rueben

(Address) 3134 Bonner Rd. E Wash

15 Filed ... 19 ... HAMILTON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1926, to Aug 8, 1929, that I last saw him alive on Aug 8, 1929 and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Pyemia — probably of Staphylococcus origin

(duration) yrs. mos. 360 ds.

CONTRIBUTORY (Secondary) Hydropsiec ordinum

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes — multiple abscesses found.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) C. B. Klaeger, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hillsboro, Kansas	8/11/29
20 UNDERTAKER Harry Miller 1531 W	ADDRESS Frombard

Spec.—2-29-28—L. F. S.—500 Bks.

E 48352

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48352

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital X 146

REGISTERED NO.

CITY OF BALTIMORE: (No. 4-30 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Horton

(a) RESIDENCE NO. New Windsor ST., Md. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ralph Horton,

6 DATE OF BIRTH (month, day, and year) June 21 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	1	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Frank J. Grimes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elsie M. Fleming.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. F. J. Grimes, (mother)
Address New Windsor, Md.

15 Filed AUG 1 1929, HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10-29

17 I HEREBY CERTIFY, That I attended deceased from 7-8, 1929, to 8-10, 1929, that I last saw h alive on 8-10, 1929, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

1 Pregnancy - bilateral pyelitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pelvic abscess / septicemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. W. Pearre, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Taylorsville Cemetery	(Aug 1 1929)

20 UNDERTAKER ADDRESS

C. M. Fritz, Winfield, Md.

Spec.—1-10-21—M&T—1500 Bks.

E 48353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

T 124

E 48353

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard Kelly Hospital ST. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Ware Bush.

(a) RESIDENCE NO. Winchester Ky ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word) M.

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~ Mr L. D. Bush

6 DATE OF BIRTH (month, day, and year) 1873 Sept 29th

7 AGE 56 Years 55 Months 10 Days 11 If LESS than 1 day, ... hrs. or .... min. 11 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scholsville Ky.

PARENTS

10 NAME OF FATHER Richard N. Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Rachel Flynn.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Clark County Ky

14 Informant L. D. Bush.

(Address) Winchester Ky

15 Filed AUG 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 1st 1929 to Aug 10 1929

that I last saw h[illegible] alive on Aug 10 1929

and that death occurred, on the date stated above, at 3 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial disease

a number.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Stroke

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 8 1929

Was there an autopsy? No Examination & Operation

What test confirmed diagnosis?

(Signed) William Hall Jr. M. D.

, 19 (Address) 1418 E. Fair Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Kentucky DATE OF BURIAL Aug 12 29

20 UNDERTAKER Chas. S. Black ADDRESS 74 2 W Frontage

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48354

CERTIFICATE OF DEATH

161-001

E 48354

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2140 Woodbery Ave ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lois Neel

(a) RESIDENCE NO. 2140 Woodbery Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2-29.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Norman E Neel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Jessie Kauffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Norman E. Neel.

(Address) 2140 Woodbery Ave.

15 Filed AUG 1 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10/29.

17

I HEREBY CERTIFY, That I attended deceased from Aug 2, 1929, to Aug 10, 1929.

that I last saw her alive on Aug 10, 1929.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 mos.)
Insufficient development.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

8/11, 1929 (Address) 846 N 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
East Berlin Pa.	Aug 11, 1929.
UNDERTAKER	ADDRESS
Ebenezer Lon	3615 Chestnut Ave

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48355

CERTIFICATE OF DEATH

111-002

E 48355

1—PLACE OF DEATH Md. General Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H. Hawkins

(a) RESIDENCE NO. 1603 Covington ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Ct. Hawkins

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER J. F. Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Virginia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hospital Record
(Address)

15 Filed AUG 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/29

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Aug 10, 1929, that I last saw him alive on Aug 10, 1929 and that death occurred, on the date stated above, at 11:06 P.M.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer

(duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) bronchio-pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 8/2/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins M. D.

(Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	8/13/29
UNDERTAKER	ADDRESS
J. H. McCauley	17 E. Fay

Cor.—10-10-29—A Co.—100 Bks.

E 48356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

181-001

E 48356

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 211 S. Bond St., 70-64 Ward)

2-FULL NAME Sophie Varasius

(a) RESIDENCE NO. 2115 Bond St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anthony Varasius

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Austria
(State or country)

PARENTS

10 NAME OF FATHER Andrew Grabuski

11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) Austria
(State or country)

14 Informant Anthony Varasius
(Address) 211 Bond St.

Filed Aug 11 1929 19 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas
while Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2115 Bond St

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) James M Linton M. D.

1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Aug 12 1929
20 UNDERTAKER Stephen J Fiatkowski Inc	ADDRESS 1000 S. Hanover Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G 11 1929

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48357

CERTIFICATE OF DEATH.

129 E 48357

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. West Baltimore General Hospital ST., WARD) REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian Cunningham

(a) RESIDENCE NO. 1612 Thomas Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs 10 mos 27 ds How long in U. S., if of foreign birth? yrs mos ds

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbur S Cunningham

6 DATE OF BIRTH (month, day, and year) Sept 14 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	23	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto Maryland.

PARENTS

10 NAME OF FATHER Andrew Streb

11 BIRTHPLACE OF FATHER (City or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Louis

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Maryland

14 Informant Wilbur S Cunningham

(Address) 1612 Thomas Ave.

15 Filed AUG 11 1929, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10 1929

17 I HEREBY CERTIFY, That I attended deceased from August 9th, 1929, to August 10th, 1929, that I last saw h[illegible] alive on August 10th, 1929 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs 2 mos ds

CONTRIBUTORY (Secondary)

(duration) yrs mos ds

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Laboratory

(Signed) J Mastagna M. D.

, 19 (Address) W. Balto Gen, Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cemetery (Hampden)	Aug 12 1929

20 UNDERTAKER W. Josiah Tyler 1600 N. North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48358

CERTIFICATE OF DEATH

44 E 48358

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Eutaw Place ST., 44-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Gombel

(a) RESIDENCE NO. 2006 Eutaw Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

a If married, widowed, or divorced (or) WIFE of the late Dr. Wm Gombel

6 DATE OF BIRTH (month, day, and year) Nov 17 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bernard Oppenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Brandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minna Gombel

(Address) 2006 Eutaw Place

15 Filed OCT 1 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1928, to Aug 6, 1929, that I last saw her alive on Aug 8, 1929 and that death occurred, on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 1 yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of about 3 months ago

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Chas Deetjen, M. D.

19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 8/12/1929

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48359

CERTIFICATE OF DEATH

21-29

REGISTERED NO. E 48359

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 Wyeth ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret A. Wacker

(a) RESIDENCE NO. 636 Wyeth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Wacker

6 DATE OF BIRTH (month, day, and year) 6.1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis J. Stangen

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Kahmer

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country) Baltimore

14 Informant Robert Wacker
(Address) 636 Wyeth St

15 Filed AUG 11 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1926, to Aug 8, 1929, that I last saw h alive on Aug 8, 1929 and that death occurred, on the date stated above, at 11 o'clock P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Dr. F. Smith, M. D.

Aug 11, 1929 (Address) 54 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster	8/12 1929
20 UNDERTAKER H. Cook	ADDRESS 1217 E. Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48360

CERTIFICATE OF DEATH

46

E 48360

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Eleventy Street 14-46 ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edith Shipley

(a) RESIDENCE NO. 3017 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Shipley

6 DATE OF BIRTH (month, day, and year) Feb 2. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	39	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John T Mills

11 BIRTHPLACE OF FATHER (city or town) Md (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Louise A Bull

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country) Baltimore

14 Informant Charles Shipley

(Address) 3017 Greenmount Ave

15 Filed AUG 11 1929 [illegible] JONES Registrar M D

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10th, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 5th, 1929, to August 10th, 1929, that I last saw h[illegible] alive on August 10th, 1929, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus with metastases to lungs and lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Louis P. Gundrum, M. D.

Aug 10. 1929 (Address) Univesity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 8/13 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48361 — 1-PLACE OF DEATH

City of Baltimore: (No. St Jos Hosp. St. 9-17 Ward)

2-FULL NAME Leonard L. Vansant

(a) RESIDENCE NO. Hallethorpe St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

R 188-103

E 48361 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reta R. Vansant

6 DATE OF BIRTH (month, day, and year) Dec 6 - 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	7	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER L. Theo. Vansant

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Queen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Greer
(Address) Talbot ave Halethorpe

15 Filed ..... 19.. C. HAMPSON JONES, M. D., Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fract. base Skull
Unconscious - Auto he was driving collided with another
Intermittent duration yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
duration yrs. mos. ds.

18 Where was disease contracted If not at place of death? Argent & Work
Did an operation precede death? — Date of
Was there an autopsy? no
What test confirmed diagnosis? Physician
(Signed) J. J. Fraun, M. D.
8/11 19 (Address) 2939 No Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Aug 12 1929
20 UNDERTAKER	ADDRESS 1203
Henry Lutz	Broadway

Cor.—10-10-29—A Co.—100 Bks.

E 48362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48362

1-PLACE OF DEATH

City of Baltimore: (No. West Balto Hosp. 16-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roda Repp

(a) RESIDENCE NO. Owenstown Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: W | 5 Single, Married, Widowed or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Repp

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 40 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Work
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Abednah Fleagle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Rowe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant C O Frost
(Address) Taneytown

Filed AUG 1 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract comp Com of the 3rd & 4th Vertebra of Cervical Region

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis Traumatic

(as Cerebral) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Accidental Fall

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L J Frame M. D.

(Address) 2439 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Owenstown Md — DATE OF BURIAL: Aug 13 1929

20 UNDERTAKER: C O Frost Son — ADDRESS: Taneytown Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

226371

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48363

CERTIFICATE OF DEATH

159-001

E 48363

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 811 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur German

(a) RESIDENCE NO. 1806 E. Federal ST. St. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

(a) If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/23/29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George A. German

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Gaither

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Reads

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 1 1929, 19 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-9-29

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1929, to Aug-9, 1929, that I last saw him alive on Aug 9, 1929, and that death occurred, on the date stated above, at 9:50 a. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 2 9

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) E. H. Campbell M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	Aug 12 1929
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St.

Cor.—10-10-29—A Co.—100 Bks.

E 48364

HEALTH DEPARTMENT—CITY OF BALTIMORE

112 E 48364

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 825 N Kenwood St., 7-11 Ward)

2-FULL NAME Fredrick Rohleder

(a) RESIDENCE NO. 825 N Kenwood St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Rohleder

6 DATE OF BIRTH (month, day, and year) Jan 18. 1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42	6	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Magistrate
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto City

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Rohleder

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Kolsher

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Katherine Rohleder
(Address) 825 N Kenwood Ave

15 Filed AUG 11 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy?

What tests confirmed diagnosis? History Phy Ex

(Signed) J. G. Geddes, M. D.

19 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Aug 11 1929

20 UNDERTAKER John Ulrich

ADDRESS 2 E Eager

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48365 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

31 ✓

CERTIFICATE OF DEATH

REGISTERED NO. E 48365

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3401 Hudson St. ST., 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Roloff

(a) RESIDENCE NO. 3401 Hudson St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Roloff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Victorya Slatkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Victorya Roloff

(Address) 3401 Hudson St.

Filed AUG 17 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1929

17 I HEREBY CERTIFY, That I attended deceased from July 7, 19 29 to July 9, 19 29

that I last saw h alive on July 9, 19 29

and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Abscess Pulmonary Tuberculosis

Mycobacteria

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/10, 19 29 (Address) 75 74 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	8 2 1929
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48366

CERTIFICATE OF DEATH

117 ✓

E 48366

1—PLACE OF DEATH CITY OF BALTIMORE (No. South Baltimore General Hospital ST., 6-12 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary E Fletcher

(a) RESIDENCE NO. 1819 N. Duncan ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John Fletcher

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	69	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Noah Arbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sauran Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Gladys Ogden
(Address) Millersville, Md.

15 Filed AUG 11 1929, C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8-29

17 I HEREBY CERTIFY, That I attended deceased from 8-6, 1929, to 8-8, 1929, that I last saw h er alive on 8-8, 1929, and that death occurred, on the date stated above, at 11.25 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Appendiceal Abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes - 8-8-29

What test confirmed diagnosis? Physical Signs

(Signed) Joseph D. Laukaitis, M. D.

8/9/29 South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Church Cemetery Carroll County, Maryland DATE OF BURIAL Aug 11 1929

20 UNDERTAKER Joseph B Cook ADDRESS 603 N Balto St

Spec.—2-29-28—L. F. S.—500 Blks.

E48367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48367

1—PLACE OF DEATH Union Memorial Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 33rd & Calvert ST. 17-W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amos D. Harrison

(a) RESIDENCE NO. Whiteford, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs A. D. Harrison

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1853.

7 AGE Years	Months	Days 28	If LESS than 1 day, hrs. or min.
75 -	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Farmer)

(b) General nature of industry, business, or establishment in which employed (or employer) At home - 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Harrison (d)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Lake (d)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs. Ralph Gammill-

(Address) 3110 Brighton St. Balto-Md.

15 Filed AUG 12 1929, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug 11, 1929, that I last saw him alive on Aug. 11, 1929 and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy. Benign -
Arteriosclerosis -
Emphysema & Chronic Bronchitis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage -

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Atypical Examination

(Signed) C. E. Cunningham, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Lawn Pa	Aug 14 1929
20 UNDERTAKER	ADDRESS
H. H. Hobbs	Forest Lawn Pa

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48368

CERTIFICATE OF DEATH

31

E 48368

1—PLACE OF DEATH

REGISTERED NO. 19-28

CITY OF BALTIMORE: (No. 423 S. Vincent St. ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph E. Bauer

(a) RESIDENCE NO. 423 S. Vincent St. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie A. Bauer(nee Mills)

6 DATE OF BIRTH (month, day, and year) June 11, 1898

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
31	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist, 031

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Bauer

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Bach

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Maryland

14 Informant Nellie A. Bauer

(Address) 423 S. Vincent St.

15 Filed AUG 12 1929, 19 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/29

17 I HEREBY CERTIFY, That I attended deceased from 6/9/29, 19 29, to 8/9/29, 19 ....., that I last saw h— alive on 8/9/29, 19 ....., and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

..... (duration) one hour yrs. ..... mos. ..... ds.

CONTRIBUTORY .....

(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Data

(Signed) Edward J. Terry, M. D.

8/13/29 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	8/12/29 19

20 UNDERTAKER Harry V. Witzke ADDRESS 153 W. Lombard St.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48369

CERTIFICATE OF DEATH.

E 48369

1-PLACE OF DEATH Hospital For the Women of Maryland REGISTERED NO. 14

CITY OF BALTIMORE: (No. ST. 27-50 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Cosell Bleakley

(a) RESIDENCE No. 3707 Rush Avenue WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Bleakley

6 DATE OF BIRTH (month, day, and year) May 26, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joe O. F. Cosell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary M. Mohr

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Md.

14 Informant Husband (Address) 3707 Rush Avenue

15 Filed AUG 12 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3 1929 to Aug. 7 1929, that I last saw h.e alive on Aug. 7 1929, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs mos 1 ds.

CONTRIBUTORY (Secondary) Puerperal Sepsis

Pregnancy (duration) yrs mos 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 3, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Edward F. Hardy M. D.

Aug. 7 1929 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Thomas Cem. DATE OF BURIAL 8/12/29

20 UNDERTAKER Harry N. Witzke, 15-31 W. Lombard ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48370

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Mercy Hospital

City of Baltimore: (No. 1232 W Pra St., 18-24 Ward) 174

2-FULL NAME Doris M Knot

(a) RESIDENCE NO. 1232 W Pratt St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	3	10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. H. Knott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Bessie Radasich

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Bessie Knott
(Address) 1232 W. Pratt St

Filed AUG 1 1929 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to Her death (Inquest, autopsy or Inquiry)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc - over
Burns 1-2 Deg
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What was confirmed diagnosis? —

(Signed) [illegible] M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 8/12/29

20 UNDERTAKER Harry A Wilkes — ADDRESS 1534 W Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. #2-29-[illegible]—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48371

CERTIFICATE OF DEATH

E 48371

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2919 Woodland Ave. ST. 27-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret L. Bayly

(a) RESIDENCE NO. 2919 Woodland Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: S. Russell Bayly

6 DATE OF BIRTH (month, day, and year): Aug. 22, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Gettysburg, Pa.

PARENTS

10 NAME OF FATHER: John H. Major

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Martha B. McSherry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Mrs. L. G. Bayly

(Address) 2919 Woodland Ave

15 Filed DEC 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to Aug 10, 1929, that I last saw h.W alive on Aug 10, 1929 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans
(Parkinson's disease)

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Gilbert, M. D.

, 19 (Address) 4754 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Cemy. Gettysburg, Pa.	Aug. 13, 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1300 Eutaw Pl.

Spec.—1-12-23—M&T—500 Bks.

E 48372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 48372
REGISTERED No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1248 E. Fayette ST. 5-8 WARD)

2-FULL NAME Anetta Stevenson

(a) RESIDENCE No. 1248 E. Fayette ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Ever Stevenson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annette Jaffrey
(Address)

15 Filed 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

I HEREBY CERTIFY, that I attended deceased from July 8 1929 to Aug 10 1929.
that I last saw her alive on Aug 10 1929
and that death occurred, on the date stated above at 9 30 m.

The CAUSE OF DEATH* was as follows:

1 Bronchopneumonia (duration) 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical
(Signed) George E Keller M. D.
8-11 1929 (Address) 608 Fairmont St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cemetery	aug 11 1929
20 UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans St

1 2 1929 HAMPSON JONES M. D. Registrar

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48373

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 48373

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1341 Hull ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margret Tyson

(a) RESIDENCE NO. 1341 Hull ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if foreign birth 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jno. Tyson

6 DATE OF BIRTH (month, day, and year) Nov 5 1872

7 AGE 56. Years 57 Months 9 Days 4 If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work.

(b) General nature of industry, business, or establishment in which employed (or employer) 687

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs [illegible] (Slade)

(Address) 1371 Hull St.

15 Filed DEC 12 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11/29.

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to Aug 11, 1929

that I last saw h[illegible] alive on Aug 11, 1929

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Cardiac debility

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. H. MacMullen M. D.

, 19 (Address) 2141 Huntingdon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz	Dec 14 1929
20 UNDERTAKER Charles P. Burns	ADDRESS 1[illegible] E Fayette

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48374

E 48374

1-PLACE OF DEATH

City of Baltimore: (No. 1449 N. Carey St., 15-23 Ward)

2-FULL NAME Lula Thomas Turner

(a) RESIDENCE NO. 1449 N. Carey St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race Col

5 Single, Married, Widowed or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) May 4-1889

7 AGE — Years 40 | Months 3 | Days 4 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Benj. Hudgins

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant John Thomas
(Address) 1449 N. Carey

15 Filed ..... 19..

AUG 12 1929

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 8th 1929

17 I HEREBY CERTIFY That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ..... death on the day stated above.
(Inquest, autopsy or inquiry)

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lungs
Sudden
(duration) ..... yrs. ..... mos.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Hobart Eckhardt M. D.
Aug 9th 1929. Coroner.

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt Auburn Cemetery — DATE OF BURIAL Aug 12 1929

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pennsylvania Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48375

CERTIFICATE OF DEATH

103 188

E 48375

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Franklin Sq. Hosp St. 15-23 (Ward)

2-FULL NAME Catharine Butler

(a) RESIDENCE NO. 1349 N. Gilmor St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	C	child

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: child

6 DATE OF BIRTH (month, day, and year): Dec-18-1924

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	4	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): Child
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Jos Butler

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Frances Wise

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: James Butler
(Address): 1349 N. Gilmore St

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture base skull due to being run down by moving auto - unavoidable accident (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Central Hemorrhage Back Spine (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gilmor & Lorman

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) C. J. Frame, M. D.

12 19 29 (Address) 1939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	Aug 12 1929
20 UNDERTAKER: Thomas E. Kelson	ADDRESS: 1803 Pleasant

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48376

CERTIFICATE OF DEATH

117

E 48376

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. 22-36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Yakaitis

(a) RESIDENCE NO. 425 S. Pca St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. — How long in U. S., if foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Caucasian	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Yakaitis

6 DATE OF BIRTH (month, day, and year) Sept 25, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46		10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tin Mill Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Sheet

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania Europe

PARENTS

10 NAME OF FATHER Anthony Yakaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania Europe

12 MAIDEN NAME OF MOTHER Magdellanis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Hospital Records

(Address)

15 Filed Aug 13 1929 HARRISON JONES, M. D. Registrar

G 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 4, 1929, to Aug 10, 1929, that I last saw h.. alive on Aug 10, 1929 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis -
Ruptured Gangrenous appendix

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 4, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos Dempsey, M. D.

(Address) 425 S. Pca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 13, 1929
20 UNDERTAKER	ADDRESS
John Grebliauckas	4233 Pca St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48377.

CERTIFICATE OF DEATH

E 48377.
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 13-59 Ward

2-FULL NAME Isadore Rosenberg

(a) RESIDENCE NO. 2903 Parkwood St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 13-1904

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	25		28 16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocery Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Grocerie
(c) Name of employer Isaac Askins

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Abraham Rosenberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Katie Deutz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant (Address) Abraham Rosenberg 2903 Parkwood Ave

15 Filed ... 19 ... HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Base of Skull due to he was driving collided with another Motorcycle individual & to road (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage Cerebral
Traumatic Shock (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? O'Donnell St East

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. Frame M. D.

8/12 1929 (Address) 2939 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave	8/12 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 48378

CERTIFICATE OF DEATH.

101-001

E 48378

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Agnes Hosp. ST. 4-7 WARD)

2-FULL NAME Mrs. Ida Shlian.

(a) RESIDENCE NO. 230 N. Harrison St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Benjamin Shlian

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Mrs. Ida Shlian
(Address) 230 N. Harrison St

15 Filed AUG 12 1929 H. LEE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/11 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-3 .1929. to 8-11 .1929.

that I last saw her alive on 8-11 .1929

and that death occurred, on the date stated above, at 4 18 P m.

The CAUSE OF DEATH* was as follows:

Cholecystetes - Uterine fibroid

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 8/8/29

Was there an autopsy? no

What test confirmed diagnosis? Typical operation

8/11 1929 (Signed) Nicholas J. Bodelli M. D.

(Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 8/12 1929

20 UNDERTAKER Jack Louis 1439 E Balto St

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 48379

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3820 Belle Avenue ST. 15-63 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Maurice Watkins

(a) RESIDENCE NO. 3820 Belle Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Medora Cecil

6 DATE OF BIRTH (month, day, and year): April 7, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Railroad

(b) General nature of industry, business, or establishment in which employed (or employer): Mail Service

(c) Name of employer: U. S. Government

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Luther M. Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Not obtainable

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

11

Informant: Mrs. Medora C. Watkins

(Address) 3820 Belle Avenue

16 Filed AUG 12 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9, 1929

17

I HEREBY CERTIFY, that I attended deceased from Nov. 3, 1928, to Aug 9, 1929.

that I last saw him alive on Aug 9, 1929

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis
Cerebral Hemorrhage
Hemiplegia about 9 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia — about 10-14 days. (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) G. Carroll Lockard M. D.

Aug 11, 1929 (Address) 4 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: 8/12 1929

20 UNDERTAKER: Henry U. Mears & Son

ADDRESS: 805 N Calvert St.

Cor.—12-9-25—A Co.—200 Bks.

t.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48380

CERTIFICATE OF DEATH.

× 185

E 48380

1-PLACE OF DEATH Md. General Hospital

11-24

City of BALTIMORE: (No. _____ St. _____ Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Gilchrist

(a) RESIDENCE NO. Rockford Ill. St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife of~~ Mary A. Gilchrist

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1850

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) New York, N.Y.

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) " "

14 Informant Mrs. Mary A. Gilchrist

(Address) Rockford Ill.

15 Filed AUG 12 1929 19 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: (Accident fell out of truck)

Uremia (duration) yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture Femur

(duration) yrs. mos. 11 ds.

(Signed) H. Gluck, M. D.

(Coroner)

Aug 10th 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death? Towson Md.

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockford Ill. Date of Burial 8/11 1929

20 UNDERTAKER H. W. Means & Son ADDRESS 805 N. Calvert St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Penn. Railroad Escort Mrs. Mary A. Gilchrist

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48381

CERTIFICATE OF DEATH

E 48381

1-PLACE OF DEATH

City of Baltimore: (No.) 5213 Elsinore Ave (St.) 27-55 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta May Humphle

(a) RESIDENCE NO. 5213 Elsinore St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Charles Humphle

6 DATE OF BIRTH (month, day and year): Sept 7-1866

7 AGE — Years: 62 — Months: 11 — Days: 2 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Chas King

11 BIRTHPLACE OF FATHER (city or town): Maryland
(State or country)

12 MAIDEN NAME OF MOTHER: Susanna Stone

13 BIRTHPLACE OF MOTHER (city or town): Maryland
(State or country)

14 Informant: Mrs. Minnie Bruce
(Address) Kenwood Md.

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

AUG 12 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Aug 9th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry)

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Error of diet

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Polk Koerber, M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. — DATE OF BURIAL: Aug. 13 1929

20 UNDERTAKER: Wm. J. Tickner & Son — ADDRESS: N. Pa Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

48382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48382

REGISTERED NO.

1-PLACE OF DEATH Womans Hospital 10-59 17

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Ann Griffin

(a) RESIDENCE NO. 2229 Callow Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	Widowed

5a If married, (widowed) or divorced HUSBAND of (or) WIFE of Edwin J. Griffin

6 DATE OF BIRTH (month, day, and year) May 2 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel J. Ringrose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary J. Biddle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Miss Mollie Griffin

(Address) 2229 Callow Ave

15 Filed AUG 12 1929 W. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to Aug 10, 1929, that I last saw her alive on Aug 10, 1929, and that death occurred, on the date stated above, at 9:25 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

9 hrs 25 min

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Pharyngeal infection abdominal wall following operation 2 mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5/31/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Earle P. Clemson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Aug 13 1929
20 UNDERTAKER	ADDRESS
Wm J Tickner & Sons	N. Y & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks. William Grooms

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 48383 — REGISTERED NO. E 48383

1—PLACE OF DEATH Baltimore City Hospitals (T. B.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 19-26 ST., (WARD)

2—FULL NAME William Grooms

(a) RESIDENCE NO. 1318 W. Mulberry st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Martha Grooms

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER W. Grooms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ellen ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ... 19.. Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Aug. 8, 1929, that I last saw him alive on Aug. 8, 1929, and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) yrs. 4 mos. 28 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia 1 week

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and Autopsy

(Signed) Jas. Gilmore, M. D.

8-8-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL Aug. 12th 1929

20 UNDERTAKER H. A. Jones

ADDRESS 111 S. Gilmor

Cor.—10-10-29—A Co.—100 Bks.

Zelzen

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48384

CERTIFICATE OF DEATH

188-001

E 48384

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore (No.) 2 X O Tracks Carey St 8 21-29 Ward)

2-FULL NAME John Zelzen

(a) RESIDENCE NO. 1173 Washington Blvd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Zelzen

6 DATE OF BIRTH (month, day, and year) April 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or min.
	56	3	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sand blaster
(b) General nature of industry, business, or establishment in whirh employed (or employer) 073
(r) Name of employer B + O. R. R.

9 BIRTHPLACE (city or town)
(State or country) Rumania

PARENTS

10 NAME OF FATHER Sam Zelzen

11 BIRTHPLACE OF FATHER (rity or town)
(State or country) Rumania

12 MAIDEN NAME OF MOTHER dont Know

13 BIRTHPLACE OF MOTHER (rity or town)
(State or country) Rumania

14 Informant Efta Zelzen
(Address) 1173 Washington Blvd

15 Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

2 X O Train Cars.
Acc.
Multiple Fracture.
(duration) yrs. mos. — da.

CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. — da.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G B Stadel M. D.

19 (Address) 1730 Berney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arridental, Suiridal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Aug 13th 1929

20 UNDERTAKER A. Jones

ADDRESS 111 S. Gilmor

Cor.—12-9-25—A Co.—200 Bks.

E 48385

L 1938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 **E 48385**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Tin 4 Pratt St., 4-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Potts

(a) RESIDENCE NO. 2113 E Balto St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 7. 1912

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	16	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Hyman Potts

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Hyman Potts

(Address) 2113 E Balto st

15 Filed DEC 2 1929 19 H. LLOYD JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 1-29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned

accidental Fell off bridge

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. J. Riley (Coroner) (Resy) M. D.

, 19 29 (Address) 1639 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — Date of Burial 8/12 1929

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48386

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH ~~Johns Hopkins~~ Hospital

City of Baltimore: (No. ~~1902 Hollins~~ St. W-28 Ward)

2-FULL NAME Bernard Frankel

(a) RESIDENCE NO. 1902 Hollins St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19 29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		3	22 21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto md.

PARENTS

10 NAME OF FATHER Adolph Frankel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Katie Abram

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Adolph Frankel
(Address) 2012 Christian st

15 Filed ... 19.. C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicidal Cyanide

CONTRIBUTORY (Secondary) Gastritis (duration) 1 yrs. mos. 1 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Inquiry

(Signed) H. C. Blades M. D.

19 (Address) 1430 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ohel Shalom Cemetery	Aug 14 1929
20 UNDERTAKER L. Levinson Bro	ADDRESS 1147 E Balto st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks.

Kolodziejski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48387.

E 48387.

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 129

CITY OF BALTIMORE: (No. 709 S. Broadway ST. 2-E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME JOSEPH KOLODIEJSKI.

(a) RESIDENCE NO. 709 S. Broadway ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maryanna Kolodziejski,

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
90	90	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Unknown,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown, Aged 11

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Mrs. Lawerince Marcinak,

(Address) 709 S. Broadway

15 Filed AUG 12 1929 HARRISON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10-29

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to August 10, 1929

that I last saw him alive on August 10, 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

(Address) 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Comm.	Aug. 13 1929.
20 UNDERTAKER M. J. Sadowski.	ADDRESS 2215 Pelham Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48388

CERTIFICATE OF DEATH

E 48388
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 9 Ward)

2-FULL NAME Lawrence Furek

(a) RESIDENCE NO. Fullerton Balto Co. St.; Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country)

PARENTS

10 NAME OF FATHER Robert W. Funk

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Mamie D. McDowell

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md.

14 Informant Johns Hopkins Hospital
(Address) Broadway

15 Filed AUG 12 1929 H. C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

*Skull Fracture
Intra Cranial Hemorrhage
(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. 11 ds.

18 Where was disease contracted If not at place of death? Fullerton

Did an operation precede death? yes Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

Signed 8/12/29 H. C. Slagle, M. D.

(Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	August 13 1929.
20 UNDERTAKER	ADDRESS
George A. Weber	705 E. Lanvale St.

Spec.—2-29-28—L. F. S.—500 Blks.

Herbert Simms

E 48389 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48389

CERTIFICATE OF DEATH

32

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) (REGISTERED NO.

CITY OF BALTIMORE: (No. ST 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Simms

(a) RESIDENCE NO. 1126 McCulloh st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Phenie Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ....., 19.... C. HAMPSON JONES, M. D.

G 17 1929 by ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to August 10, 1929, that I last saw h... alive on Aug. 10, 1929, and that death occurred, on the date stated above, at 10.50 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Polyserousitis

Tuberculous Meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Jos. Friend Jr. M. D.

8-10, 19.. (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters cem — DATE OF BURIAL 8/13 1929

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pear

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48390 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 48390

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1009 S Clinton ST. 76-1 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Gruel

(a) RESIDENCE NO. 1009 S. Clinton St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Kathryn Gruel

6 DATE OF BIRTH (month, day, and year) Aug. 17- 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	23	

8 OCCUPATION OF DECEASED now recently formerly

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar mfg factory

(c) Name of employer Brit G. Sutz & Bro. City

9 BIRTHPLACE (city or town) (State or country) not known Germany

PARENTS

10 NAME OF FATHER George Gruel

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country) not known

14 Informant Mary Gruel

(Address) 1009 S. Clinton St

15 Aug 12 1929 HAMPSON JONES, M. D. Registrar

or

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9- 1929

17 I HEREBY CERTIFY, That I attended deceased from several years prior to Aug 9 19 29

that I last saw h alive on Aug 9 19 29

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial hepatitis

Ulcer of stomach - several years. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) N. W. Wright M.D for D. W. Jones M. D.

8/10/ 1929 (Address) 1011 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz's Cem.	Aug 13 1929
20 UNDERTAKER	ADDRESS
George W. Zinkler	1737 E. Eager St

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Gilley 5103 Harford Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48391

E 48391

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3203 Chelsey Ave ST. 8-16 WARD)

2—FULL NAME Margaret Catherine Simmons

(a) RESIDENCE NO. 2312 Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John B Simmons

6 DATE OF BIRTH (month, day, and year) Aug 17 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Lonard, Md

PARENTS

10 NAME OF FATHER Bernard Flanagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md

12 MAIDEN NAME OF MOTHER Sarah L Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward J Simmons

(Address) Catonsville Md

15 Filed AUG 12 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9. 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/1, 19 29, to 8/9, 19 29

that I last saw h alive on 8/9, 19 29

and that death occurred, on the date stated above, at 5:25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gall Bladder, Liver etc

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Geo W. Gilley, M. D.

, 19 (Address) 5103 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lonard Md	8/12 19 29
20 UNDERTAKER H. Cook	ADDRESS 2142 Pace St

Important. See instructions on back of this certificate.

Spec.—12-9-25—A Co.—200 Bks.

Bossyns

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48392

CERTIFICATE OF DEATH.

48 E 48392

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3216 Elgin Av St. 15-61 Ward)

2-FULL NAME Pauline M Bossyns

(a) RESIDENCE NO. 3216 Elgin Av St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 65 yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (late) Joseph Bossyns (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5th 1845

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	84	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) France

PARENTS

10 NAME OF FATHER Chirein

11 BIRTHPLACE OF FATHER (city or town):

(State or country) France

12 MAIDEN NAME OF MOTHER Marie Chirein

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) France

14 Informant Mr B Bossyns

(Address) 3216 Elgin Ave

15 Aug 12 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1929, to Aug 11 1929, that I last saw h__ alive on Aug 11 1929, and that death occurred, on the date stated above, at 3 45 P.M.

The CAUSE OF DEATH* was as follows: Cancer of Face Epithelioma & Carcinoma of Intestines

(duration) 2 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Senile Exhaustion

(duration) ___ yrs. 3 mos. ___ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Visible Growths

(Signed) Jos O E Calvert, M. D.

Aug 11, 1929 (Address) 325 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Aug 13, 1929

20 UNDERTAKER: Margaret S. Flynn ADDRESS 1402 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

July Myohl.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48393

CERTIFICATE OF DEATH

34 ✓ E 48393

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mpl Gen Hosp 12-51 WARD)

2—FULL NAME Miss Lillie Myohl

(a) RESIDENCE NO. 2435 Maryland Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1873

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
56	2 3	10 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Myohl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate Schuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant

(Address) Hospital Record

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10/29

17 I HEREBY CERTIFY, That I attended deceased from 8/2/29, 19..., to 8/10/29, 19..., that I last saw h[illegible] alive on 8/10/29, 19..., and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Ch Pleural Colon
Ruptured

(duration) 10 yrs. mos. da.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) [illegible] M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Aug 13 1929
20 UNDERTAKER Charles F. Kechner	ADDRESS 1132 Hollins

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48394

CERTIFICATE OF DEATH.

E 48394

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 Lemmon St. ST. 18-29 WARD)

2-FULL NAME Ella Hollis,

(a) RESIDENCE NO. 834 Lemmon St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ono

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Hollis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md.

12 MAIDEN NAME OF MOTHER Lemmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Carrie Alsup (Address) 834 Lemmon st

15 Filed 1 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 9. 1929. to Aug 11. 1929.

that I last saw h/r alive on Aug 11. 1929.

and that death occurred, on the date stated above, at 5 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia.

(duration) 1 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary) Whooping Cough.

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no. —

What test confirmed diagnosis? Physical Examination

(Signed) J. Thaxton Jones, M. D.

19 (Address) 888 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemty

DATE OF BURIAL 8/12 1929

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1349 Hanover St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48395 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48395

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1606 N Smallwood St) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret McDonald.

(a) RESIDENCE NO. 1606 N Smallwood St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Roderick McDonald.

6 DATE OF BIRTH (month, day, and year) 4-6-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Hayden.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Ryan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. James F. McDonough (Address) 1606 N. Smallwood St.

15 DEC 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 29.

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1929, to Aug 11th, 1929, that I last saw h[illegible] alive on August 11th, 1929 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Arteio-Sclerosis (Senile)

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical

(Signed) Wm Kuhlman M. D.

8/12, 1929 (Address) 1701 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westwood Cemetery

DATE OF BURIAL 8-13-29

UNDERTAKER Martin Fahey & Sons

ADDRESS 847 W. Fayette St.

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 48396

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mt. Church Home and Infirmary

CITY OF BALTIMORE: (No. North Broadway ST., 27-44 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruby Schafer.

(a) RESIDENCE NO. 6316 Wilshire Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs or 29 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward Schafer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Rose Sandkuhler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant
(Address)

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 1929, to Aug 11 1929, that I last saw her alive on Aug 11 2.45, 1929, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis 6 days

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dean H. Smith, M. D.

, 19 (Address) Chamberlain & Taf. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL Aug 12 1929

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Alice Windham

E 48397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 48397

1—PLACE OF DEATH Baltimore City Hospitals (T.B. W.) REGISTERED NO. 17-26

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Windham

(a) RESIDENCE NO. 730 Pierce st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Windham

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Alex Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rachel ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) UNIVERSITY OF MARYLAND

15 Filed 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to August 7, 1929, that I last saw her alive on August 7, 1929 and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) [signature], M. D.

8-7-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER Commissioner Health

DATE OF BURIAL 19

ADDRESS

AUG 12 1929

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48398

CERTIFICATE OF DEATH

49

E 48398

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 5-8 WARD)

*REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Bowman

(a) RESIDENCE NO. 10 S 1 Hillen St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Edward Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary Land

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary Land

14 Informant Hospital Record
(Address)

15 Filed ..., 19 ... Registrar

12 1929

C. HAMPSON JONES, M. D.
10 THE ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/6/29

17 I HEREBY CERTIFY, That I attended deceased from 8/5, 1929, to 8/6, 1929, that I last saw him alive on 8/6, 1929 and that death occurred, on the date stated above, at 10 40 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma penis - urethral fistula - Syphilis, chronic - syphilis, etc

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Hampson Jones, M. D.

8/6, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER [redacted]	ADDRESS

UNIVERSITY OF MARYLAND

AUG 12 1929

Important. See instructions on back of certificate.

Cor.—10-20-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48399 2

113 E 48399

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1011 N. Stricker St., 16-27 Ward)

2-FULL NAME Raymond Fogarced

(a) RESIDENCE No. 1011 N. Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months: 2 | Days | IF LESS than 1 day..... hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER: Matilda Harried

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Madelyn Fogarced
(Address) 1011 N. Stricker St.

15 Filed AUG 12 1929 Registrar C. HAMPSON JONES, M. D.

3818 THE WARE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 8th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and ... find that said deceased came to ... death (autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Hamilton Coroner M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER: [illegible] — ADDRESS AUG 12 19

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48400

CERTIFICATE OF DEATH

E 48400

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn Stallings

(a) RESIDENCE NO. 1027 Boyd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child —

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Stallings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Krause

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Walter Stallings

(Address) 1027 Boyd St

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 11, 1929, to August 11, 1929, that I last saw her alive on August 11, 1929 and that death occurred, on the date stated above, at 7:15 p m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) 0 yrs. 0 mos. 22 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? 1027 Boyd St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Irby M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	8/13 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48401 31 N **E 48401**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3101 Mary ave St. 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles P. Fenner

(a) RESIDENCE NO. 3101 Mary avenue St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta R. Fenner

6 DATE OF BIRTH (month, day, and year) aug 3 - 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	54	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Plumbing Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Same

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Fenner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Barbara Gerber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Switzerland

14 Informant Mrs Charles P. Fenner

(Address) 3101 Mary avenue

15 Filed C. HAMPSON JONES, M. D. Registrar

12 1929 By RRP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 August 11 - 1929

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to August 11, 1929

that I last saw him alive on August 11, 1929

and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 4 mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

Aug 11 1929 (Address) Hamilton Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Parkwood Cemetery	Aug 13 1929

20 UNDERTAKER Frederick Lauchheimer & Son ADDRESS Fulleton

Filling blanks be carefully supplied. Avoid abbreviations. Write plainly in ink. Physicians should be particular to see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48402

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48402

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Harzarik

(a) RESIDENCE NO. 1201 E Kanwood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Records, Baptismal City Hospitals.
(Address)

15 Filed 12 1929, 19 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10, 1929.

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1929, to August 10, 1929, that I last saw him alive on August 10, 1929, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Exam; Lab.

(Signed) Marvin M. Hyslop, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Aug 13 1929
20 UNDERTAKER	ADDRESS
Jos J Stein	152 Eutaw

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48403

CERTIFICATE OF DEATH

90 E 48403

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 2-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Dessell

(a) RESIDENCE NO. 411 S. Duncan ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. How long in U. S., if foreign birth? 8 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profesalon or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Albert Strohmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Hout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 12 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 1, 19 29 to August 10, 19 29

that I last saw her alive on August 10, 19 29

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hist. & P.E.

(Signed) Warren H. McClean, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 14 1930
20 UNDERTAKER	ADDRESS
Jos. J. Hess	136 Eutaw

Spec.—2-29-28—L. P. S.—800 Blks.

E 48404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

E 48404

1—PLACE OF DEATH

REGISTERED NO. 28-64

CITY OF BALTIMORE: (No. 3211 Brightwood Ave ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Jane Wood

(a) RESIDENCE NO. 3211 Brightwood Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph R. G. Wood

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Grafton
(State or country) West Virginia

PARENTS

10 NAME OF FATHER William Morrow

11 BIRTHPLACE OF FATHER (city or town) St. Field
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Caroline Ritter

13 BIRTHPLACE OF MOTHER (city or town) Owings Mills
(State or country) Maryland

14 Informant Mr. Wellington G. Wood
(Address) 3211 Brightwood Ave.

15 Filed ..... 19 ..... Registrar

HAMPSON JONES, M. D.

12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to Aug 8, 1929, that I last saw her alive on Aug 8, 1929 and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) General Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Nov 1928

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Edw. Wiring, M. D.

8/10, 1929 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug. 12 1929
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 48405

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2245 Washington ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lorenz Zaminski

(a) RESIDENCE NO. 2245 Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Zaminski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	71	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Frank Zaminski

(Address) 1618 Eastern Ave

15 Filed 8 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Aug 9, 1929, that I last saw him alive on Aug 7, 1929 and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 5 yrs
Chr Int Nephritis 3 "

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sphygmomanometer & Urinary Tests

(Signed) J M Dilworth, M. D.

Aug 10, 1929 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	8/13 1929
UNDERTAKER William Fiaschetti	ADDRESS 1618 Eastern Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48406 E 48406

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... 11-20 WARD)

2-FULL NAME Sally May Johnson.

(a) RESIDENCE No. 642 N. Queen ST., Martinsburg W. Va. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: William A. Johnson.

6 DATE OF BIRTH (month, day, and year): Aug. 1, 1885

7 AGE — Years: 44 — Months: 0 — Days: 11 — If LESS than 1 day, hrs. or min.: .....

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Martinsburg. West Virginia.

PARENTS

10 NAME OF FATHER: H. S. Small.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Martinsburg West Virginia
12 MAIDEN NAME OF MOTHER: ? Burr
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Jefferson Co. W. Va.

14 Informant (Address): William A. Johnson.

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

AUG 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 12, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1929. to Aug. 12, 1929. that I last saw her alive on Aug 12 1929. and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute myelogenous Leukemia.

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Rudolph L. Schork M. D.

. 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Martinsburg W Va

DATE OF BURIAL: Aug 17 1929

UNDERTAKER: John O Mitchell Inc

ADDRESS: 19 E. Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Faulkner - 119 N Milton Ave

E 48407

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 48407

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 14-20

CITY OF BALTIMORE: (No. 209 Mc Mechen ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F Stuck

(a) RESIDENCE NO. 209 Mc Mechen ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Cumberland
(State or country) Md

PARENTS

10 NAME OF FATHER John F Stuck

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hornmyer

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs E Carter
(Address) 209 McMechen St

15 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1929, to One call, 19....,
that I last saw h... alive on Aug 9th, 1929
and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:

Endocarditis
uncertain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart
uncertain
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Faulkner, M. D.

. 19 (Address) 119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	8/13 1929
20 UNDERTAKER H. A. Cook	ADDRESS 1217 E Fayette St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Blks.

E 48408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48408

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1439 Battery ST. 24-34 WARD)

2—FULL NAME Joseph Barranco.

(a) RESIDENCE NO. 1439 Battery ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Barranco.

6 DATE OF BIRTH (month, day, and year) Jan 17 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Charles Barranco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Rosie D'Jatta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Son.

(Address)

15 Filed 12 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-12-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1929, to Aug 12, 1929, that I last saw him alive on Aug, 1929 and that death occurred, on the date stated above, at 4:30 P M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Mitchell, M. D.

8/12, 1929 (Address) 1279 William H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	8/14 1929
20 UNDERTAKER	ADDRESS
J. Fenw McCully	130 E Fort.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48409

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 23-34 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James J. Dyer

(a) RESIDENCE NO. 1505 Clarkson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: John Dyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Gyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed 12 1929, 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 11, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 7, 19 29 to August 11, 19 29

that I last saw him alive on August 11, 19 29

and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Primary at home Tubercular Laryngitis

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Marvin M. McLean, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Harford Ave	8/13 1929
20 UNDERTAKER	ADDRESS
J. Few McCully	130 E Fort

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48410

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48410

CERTIFICATE OF DEATH

X 1515

1-PLACE OF DEATH West Baltimore General. 16-68

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. (WARD)

2-FULL NAME Mrs. Mary Stewart.

(a) RESIDENCE NO. 2310 Birch Drive ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 75 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. R. Stewart

6 DATE OF BIRTH (month, day, and year) March 4, 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
81	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Mrs Chalmers - (niece)

(Address) 2310 Birch Drive

15 Filed C. HAMPSON JONES, Registrar M. D.

12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug. 11, 1929

17

I HEREBY CERTIFY, That I attended deceased from aug. 3, 1929, to aug. 11, 1929, that I last saw her alive on aug. 11, 1929 and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene - Left foot

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Rastagna, M. D.

8/11, 1929 (Address) West. Balto. General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Western Cemetery Aug-13 1929.

20 UNDERTAKER — ADDRESS

Stewart & Co Balto.

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 **E 48411**

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 739 S. Conkling ST., 26 WARD)

2—FULL NAME Margaret L. Zeller

(a) RESIDENCE NO. 739 S. Conkling ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 30 ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Zeller M.

6 DATE OF BIRTH (month, day, and year) May 12th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas W. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary M. Lewall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Robert T. Zeller son

(Address) 3212 Pinewood ave.

15 Filed 12-1929 G. HAMPSON JONES, M. D., Registrar.

Per ARS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11th/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 . 1929 . to Aug 11 . 1929.

that I last saw h e alive on Aug 11 . 1929

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

(duration) ... yrs. mos. 2 ds. Chr. Nephritis & arterial

Secondary) Hypertension (duration) 13 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical exam Ua.

(Signed) Wm. R. Straughn M. D.

8/13/29 (Address) 2225 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Aug. 14 1929
20 UNDERTAKER Reilly & Zeller Inc.	ADDRESS 4008 Reisterstown Rd.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185

E 48412

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) West Balto Gen Hosp St. 15-68 (Ward)

2-FULL NAME Wm F. Parks.

(a) RESIDENCE NO. 1921 Ridgewood St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Parks

6 DATE OF BIRTH (month, day, and year) Jan 6-1868

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
61	6	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Margt V. Parks
(Address) 1921 Ridgewood

15 Aug 12 1929 C. HAMPSON JONES, M. D. Registrar

Dnf

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH was as follows:*

Accident Fell Off Steps
On Head
Cerebral Hemorrhage
Fractured Skull

CONTRIBUTORY (Secondary) yrs. mos. ds.

(duration)

18 Where was disease contracted if not at place of death? 1921 Ridgewood

Did an operation precede death? Date of Aug 11

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) H. E. Smith, M. D.
Aug 12th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Aug 12 1929

20 UNDERTAKER Chenowith & Son — ADDRESS 36 15 Chestnut Ave

IT IS IMPORTANT that this certificate should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E [redacted]13 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48413

CERTIFICATE OF DEATH.

166

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. 7-8-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Bissett

(a) RESIDENCE NO. 16 South Fremont Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Bissett

6 DATE OF BIRTH (month, day, and year): 3/28/1890

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
39	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Gustav Fiedl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Heurich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Charles Bissett

(Address) 16 S Fremont Road

15 Filed 12 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-10 1929

17

I HEREBY CERTIFY, That I attended deceased from 7-28, 1929, to 8-10, 1929, that I last saw her alive on 8-10, 1929, and that death occurred, on the date stated above, at 3 20 p m.

The CAUSE OF DEATH* was as follows:

Mercuric chloride poisoning - suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk — DATE OF BURIAL: Aug 13 1929

20 UNDERTAKER: Geo L. Schwab — ADDRESS: 2101 Frederick

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48414 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 48414**

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Fallow Hyatt Saratoga E/S 4428 (Street) (Ward)

2-FULL NAME Jos H Davis

(a) RESIDENCE NO. 415 S Mount St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida J. Davis

6 DATE OF BIRTH (month, day, and year) April 28 1881

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
48	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jacob T. Davis

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Anna M. Georges

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Ida J. Davis
(Address) 415 S. Mount St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

12 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 - 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. ..... mos. 1 da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 da.

18 Where was disease contracted If not at place of death? —

Did operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Exs

(Signed) Ly Gladden M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Aug 15 1929
20 UNDERTAKER Geo L. Schwob	ADDRESS Pikesville Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48415

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 25-7 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Mielke

(a) RESIDENCE NO. 2809 Maisel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

.a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1/12/21

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
8	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Conrad Mielke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Mielke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 12 1929 C. HAMPSON JONES, M. D. Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11 1929

17

I HEREBY CERTIFY, That I attended deceased from August 6, 1929, to August 11, 1929

that I last saw him alive on August 11, 1929

and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

General peritonitis, following appendicitis, acute, with perforation

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient's home.

Did an operation precede death? yes Date of Aug 6, 1929

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Clarence E. Snodgrass Jr. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	8/14/29
20 UNDERTAKER	ADDRESS
Harry A. Wilke	153 W Lombard

Spec.—2-29-28—L. F. S.—500 Blks.

E 48416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48416

1—PLACE OF DEATH

REGISTERED NO. 20-28

CITY OF BALTIMORE: (No. 411 S. Payson St. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie G. Howard

(a) RESIDENCE NO. 411 S. Payson St. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Joseph L. Howard.

6 DATE OF BIRTH (month, day, and year) May 12, 1865.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER R. H. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William J. Young

(Address) 2569 Frederick Ave.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

G 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1929

17

I HEREBY CERTIFY, That I attended deceased from July 1 1929 to Aug 10 1929

that I last saw her alive on Aug 10 1929

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

8/12, 1929 (Address) 54 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	8/13/29

20 UNDERTAKER Harry N. Wiffle, 531 W. Lombard St.

ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital REGISTERED NO. E 48417

CITY OF BALTIMORE: (No. 4-20 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Franklin Brown

(a) RESIDENCE NO. Lutherville Md ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary R Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dr David F Fisher

(Address) University Hospital

15 Filed Aug 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 26th 1929 to August 16th 1929

that I last saw h in alive on August 10th 1929

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac failure of Congestive Type

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Carcinoma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Louis F Tendry, M. D.

8-16-1929 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bridgeton, N. J.	Aug 13 1929
20 UNDERTAKER W. H. Cook	ADDRESS 1217 E Fayette St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks. Dr H E Byers 616 N Woodington Ave

E 48418 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 48418

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1030 N Baltimore ST. 18-N WARD)

2—FULL NAME Joseph P Jordan

(a) RESIDENCE NO. 1030 N Baltimore ST. ..... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Almyra Gordon

6 DATE OF BIRTH (month, day, and year) Oct 9. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Music Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md Va

PARENTS

10 NAME OF FATHER Andrew Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Wine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James L Jordan

(Address) 1030 N Baltimore St

15 Filed AUG 13 1929 19 .....

HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 6 1929 to Aug 12 1929 that I last saw h alive on Aug 12 1929 and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis + Endocarditis

(duration) 15 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 4 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? Usual signs

(Signed) H E Byers M. D.

8. 12 1929 (Address) 616 Woodington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	8/14 1929
20 UNDERTAKER J. M. Cook	ADDRESS 1217 E Cold 4

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48419

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 917 Eutaw Place (Ward) 90

2-FULL NAME Clara Herman

(a) RESIDENCE NO. 917 Eutaw Place Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Feb 9 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	67	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Paul Herman

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Lena Bowman

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Caroline Herman
(Address) 917 Eutaw Place

15 Filed ..... 1929 C. HARRISON JONES, M. D. Registrar

G 13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Reuben Fleischer, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	5/13/1929

20 UNDERTAKER David Sondheim ADDRESS 1128 Mount Royal Ave.

If DEATH occurred in a hospital or institution, the NAME and not the street and number should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 48420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-001

E 48420

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (a) No. 5616 Pilimico Road 27-55 Ward

2-FULL NAME Jesse F. Durbin

(a) RESIDENCE NO. 5616 Pilimico Road St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Ida V. Durbin

6 DATE OF BIRTH (month, day, and year) July 31 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75		11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) O.S.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Durbin
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Ridea
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mr Ida V. Durbin
(Address) 5616 Pilimico Road

Filed AUG 13 1929 G. HAMPSON JONES, M. D.
Per [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:
Chronic Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. H. Norris M. D.
Coroner
8/12 1929 (Address) 3532 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Date of Burial Aug 13 1929

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Falls Road

Don't fail to answer every question. If unknown or doubtful, say so. Do not use "Unknown" or "Infant" for AGE. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

227338 E 48421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x 90 ✓ E 48421

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julius Shaffer

(a) RESIDENCE NO. Fayette with N-C ST. Mby 134 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mab	white	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1879

7 AGE	Years	Months	Days	If LESS than 1 day... hrs. or... min.
	50	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Optometrist do

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 15 1924 C. HAMPSON JONES, M. D. Registrar

Per Beck

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12, 1924

17

I HEREBY CERTIFY, That I attended deceased from July 19, 1924, to Aug 12, 1924, that I last saw him alive on Aug 12, 1924 and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general symptoms

(Signed) R. Hoops Smith, M. D.

Aug 12 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	Aug 13 1924
20 UNDERTAKER L Levinson Bro	ADDRESS 1127 E Balto St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 48422

E 48422
1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1506 Mount ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lola M. Smith

(a) RESIDENCE NO. 1506 Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): April 4-29

7 AGE — Years: — Months: 4 Days: 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Bessie Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: John Smith (Address): 1506 N. Mount St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 12, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10th, 1929, to Aug. 12th, 1929, that I last saw h[illegible] alive on Aug 12th, 1929 and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. Brown, M. D.

, 19 (Address) 1[illegible]3 Monroe.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 8/13/29

20 UNDERTAKER: Mrs. Lucy H. Holland — ADDRESS: 163 Druid Hill

Important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

John Riesett

E 48423

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48423

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 604 Hanover St. St. 22-30 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Riesett

(a) Residence No. 604 Hanover St., Ward.
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sadie Riesett

6-DATE OF BIRTH (month, day and year) Dec 22 1891

7-AGE. 37 yrs. 7 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Sexton in Church

(b) General nature of industry, business, or establishment in which employed (or employer) 6th

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS:

10-NAME OF FATHER. John Riesett

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto.

12-MAIDEN NAME OF MOTHER. Margrett Riggins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) Sadie Riesett

(Address) 604 Hanover St

15- This 13 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 13/29

17- I HEREBY CERTIFY, That I attended deceased from ..... 1928 to Aug. 12 1929

that I last saw ~~him~~ alive on Aug. 12 1929

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 127 N. Lee St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. D. Smith M. D.

Aug. 13 1929 (Address) 129 N. Lee St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holly Grove Cemetery

DATE OF BURIAL. 8/16 1929

20-UNDERTAKER. F. A. Krauss Son

ADDRESS 703 Hanover St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48424

E 48424

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp ST. 14-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte Spain

(a) RESIDENCE NO. 405 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ John Spain

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
-	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Richard Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frances Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Johan Spain

(Address) 405 n mount st

15 Filed AUG 13 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to Aug 11, 1929, that I last saw her alive on Aug 11, 1929 and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Bad Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of June 11 29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy.

(Signed) Jas Harold J., M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Princeton Va	Aug 13 1929
20 UNDERTAKER	ADDRESS
Joseph Hardy	409 N Mount St

Important. See instructions on back of certificates.

AUG 13 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 48425 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 **E 48425**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 n. Ellwood av ST. 6-11 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arline Marie Clayson

(a) RESIDENCE NO. 19 n. Ellwood Av ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 12, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Ross Clayson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Antonetta Carrico

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Allegheny N Y

14 Informant Father Ross Clayson

(Address) 19 n Ellwood ave

15 8 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 12, 1929.

that I last saw h~~e~~r alive on Aug 12, 1929.

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature ity

(duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) (Foetus).

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dudley P Bowe, M. D.

8/12, 1929 (Address) 1904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem

DATE OF BURIAL aug 13 1929

20 UNDERTAKER Frank V. Pistorius

ADDRESS 2415 E. Balto st

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 22 7806 E 48426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48426

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patsy Scotland

(a) RESIDENCE NO. 625 E. 28th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	~~Married~~ Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of James Scotland

6 DATE OF BIRTH (month, day, and year) ~~Feb 2 1883~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Cook~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER L Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Jannifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 FILED AUG 13 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11-1929

17

I HEREBY CERTIFY, That I attended deceased from August 2, 1929, to August 11, 1929, that I last saw her alive on August 11, 1929 and that death occurred, on the date stated above, at 8 20 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Hypertension. Chronic nephritis. Cerebral hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis ulcer large

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 9, 1929

Was there an autopsy? No

What test confirmed diagnosis? B.P. determination. Urinalysis.

(Signed) H. E. Everett, M. D.

8/12, 1929 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 15 1929
20 UNDERTAKER George P. Gibson	ADDRESS 1735 Druid Hill Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48427

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48427

CERTIFICATE OF DEATH

23

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 26-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Maser

(a) RESIDENCE NO. 6437 Cedonia Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~October 7, 1900~~ July 7th 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER George Maser

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Ditmont

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Records
(Address) Baltimore City Hospitals.

15 Filed AUG 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to August 12, 1929,

that I last saw him alive on August 12, 1929

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica

(duration) yrs. 7 mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & exam. Lab.

(Signed) Warren H. McCleary M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakwood Cemetery	Aug. 14 1929
20 UNDERTAKER	ADDRESS
Frederick Lassahn & Son	Ed Fullerton

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48428 — **CERTIFICATE OF DEATH** — 129 ✓ — **E 48428**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4010 Overlea Ave. ST., 27-42 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida L. Sammeng

(a) RESIDENCE NO. 4010 Overlea Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Samuel Sammeng

6 DATE OF BIRTH (month, day, and year) May 30 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Hamilton Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J. Lond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm. Sammeng

(Address) Baltimore Md.

15 Filed Aug 13 1929 C. HARRISON JONES, M. D. Registrar

Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 29

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Aug 10, 1929, that I last saw h[illegible] alive on Aug 9 1929 and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation
Hypertension
Arteriosclerosis 2 yrs
Acute Cardiac Dilatation

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

Aug 12 1929 (Address) 606 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmony Cemetery	Aug 13 1929
20 UNDERTAKER	ADDRESS
Stew & Son Inc.	Sykesville Md.

important. See instructions on back of certificates.

Spec.—1-10-21 M&T (500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 VE 48429

E 48429

REGISTERED NO. 15-61

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3611 Windsor Mill Rd St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide J. Edwards

(a) RESIDENCE NO. 3611 Windsor Mill Rd St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	77	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Francis Carver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliza J. Dolphin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. J A Edwards

(Address) Estend & Ridgelyn

Filed AUG 13 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) Aug 12 (day) (year) 29

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929 to Aug 12, 1929.

that I last saw h.. alive on Aug 11, 1929

and that death occurred, on the date stated above, at 8 35 m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Tibbett, M. D.

, 19 (Address) 2720 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 15 1929
20 UNDERTAKER George J. Lorch	ADDRESS 153 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 48430

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48430

STATE BIRTH [illegible]

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 N Greene St. 2 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Fisher

(a) RESIDENCE NO. 117 N Greene St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
45?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 [illegible] 19 [illegible] M. D.

AUG 13 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY Exhaustion

(Secondary)

(duration) yrs. mos. ds.

8/7/29 (Signed) J. E. Rhodes, M. D.

(Coroner)

, 19 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 23/1930 Allentown Pa

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER ADDRESS

AUG 13 1929

1816 Hanover St

UNIVERSITY OF MARYLAND

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 48431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1829

E 48431

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Penn Pier 5 Pratt St. 4-6 St., _____ Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: about 30 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

14 Informant .....

(Address)

Filed AUG 13 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

Accidental

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

Aug 2 1929 (Address) 1629 Bway

(Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY. Date of Burial 19

20 UNDERTAKER [illegible] ADDRESS [illegible] AUG 1 1929

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

tion should be carefully supplied. AGE

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48432

CERTIFICATE OF DEATH

E 48432

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 16-22 WARD) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Grade

(a) RESIDENCE NO. 1113 N. Gilmore ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. ? How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elijah Grade

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) ?
(State or country) Virginia

PARENTS

10 NAME OF FATHER Tyler Tinsdale

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen King

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Virginia

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed AUG 13 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 19 29 to August 5, 19 29

that I last saw h e r alive on August 5, 19 29

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Fatal, c insufficiency
Cardiac Insufficiency

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.E. Lab

(Signed) Marvin M McLan, M. D.

8-9, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL AUG 13 1929

20 UNDERTAKER [illegible]

ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48433

90 ✓

CERTIFICATE OF DEATH

27-53

REGISTERED NO. E 48433

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5712 Roland Avenue ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Dresman

(a) RESIDENCE NO. 5712 Roland Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. - mos. - ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 19, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

065

9 BIRTHPLACE (city or town) Cumberland
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Dresman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Convent of Visitation Reco
(Address) 5712 Roland Avenue

15 Filed AUG 13 1929 HAMILTON JONES, M. D. Registrar

Bur

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-12-29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19 28, to Aug. 19 29,
that I last saw h e alive on Aug. 12, 19 29
and that death occurred, on the date stated above, at 2.05 p m.
The CAUSE OF DEATH* was as follows:

Cysto-pyelonephritis. (Generalized urinary tract infection)
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senility. Chronic Myocarditis
(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Examination

(Signed) Charles O'Donovan Jr M. D.

. 19 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/12 19 29

20 UNDERTAKER Henry W. Bears Son ADDRESS 805 N. Calvert

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48434

100-001

CERTIFICATE OF DEATH

E 48434

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 218 S. ann ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Calva

(a) RESIDENCE NO. 218 S ann ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divnrced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant. ohd

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore md.

PARENTS

10 NAME OF FATHER: Adam Calva

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md.

12 MAIDEN NAME OF MOTHER: Rose Wolska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md.

14 Informant: Adam Calva

(Address): 218 S. ann st.

15 Filed AUG 13 1929, HAMPSON JONES, M. D. Registrar

G

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12-1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 7, 1929, to Aug 12, 1929, that I last saw h alive on August 12, 1929 and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) Samuel Silverstein M. D.

, 19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	Aug. 13 1929.
20 UNDERTAKER	ADDRESS
George A Weber	705 S ann st

Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48435

CERTIFICATE OF DEATH

129 **E 48435**

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3112 E. Baltimore St. (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Flaherty

(a) RESIDENCE NO. 3112 E. Balto St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Flaherty

6 DATE OF BIRTH (month, day, and year): Mar. 1853

7 AGE — Years: 76 — Months: 5 — Days:

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Watchman

(c) Name of employer: Baltimore

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: don't know

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ire.

12 MAIDEN NAME OF MOTHER: Mary Sullivan

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Ireland

14 Informant (Address): Anne Flaherty 3112 E Balto St.

15 Filed AUG 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929: Aug. 12

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Aug 12, 1929, that I last saw h[illegible] alive on Aug 11, 1929, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Debility of aged

Chronic myocarditis & Nephritis

Generalized arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Uremia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) T. Joseph Toohey M. D.

. 19 (Address) 800 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Com.

Date of Burial: 8/14 1929

20 UNDERTAKER: J. A. Moran

ADDRESS: 3906 E Balto

be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48436

CERTIFICATE OF DEATH

E 48436

1—PLACE OF DEATH St. Helena

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 6539 Ballo Ave. ST., Nov 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Steve Giez or Gratz.

(a) RESIDENCE NO. 6539 Ballo Ave. ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Gratz.

6 DATE OF BIRTH (month, day, and year) Aug 25th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	11	15	
	54	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer at

(b) General nature of industry, business, or establishment in which employed (or employer) Bella Steel Co.

(c) Name of employer Sparrows Point

9 BIRTHPLACE (city or town) Austria
(State or country) Hungary.

PARENTS

10 NAME OF FATHER ? Austria

11 BIRTHPLACE OF FATHER (city or town) ? Hungary
(State or country)

12 MAIDEN NAME OF MOTHER ? Austria

13 BIRTHPLACE OF MOTHER (city or town) Hungary
(State or country)

14 Informant Anna Gratz wife

(Address) 6539 Ballo Ave St Helena

15 Filed AUG 13 1929, 19 C. HAMPSON JONES, M. D.
By CRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10th /29

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929, to Aug 10, 1929, that I last saw h[illegible] alive on Aug 9, 1929 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Acute dilitation of Heart.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. E. Shaffer, M. D.

, 19 (Address) Sparrows Point, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Aug 14 1929
20 UNDERTAKER Lilly + Gilmore Inc.	ADDRESS 400 N Wolfe St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

22916
E 48437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 48437

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Hefner

(a) RESIDENCE NO. Richwood-Ln- ST., 2a — WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hannie

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5-2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Va-

PARENTS

10 NAME OF FATHER Jim Hefner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va-

12 MAIDEN NAME OF MOTHER Rena Howe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va-

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

Filed AUG 13 1929, 19 C. HAMPSON JONES, M. D.

By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1929, to Aug 13, 1929, that I last saw him alive on Aug 13, 1929 and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, Benign

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 9 Aug. 29

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) E. H. Campbell, M. D.

, 19 (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richwood Va	8/13/29
20 UNDERTAKER Joseph Ahrens	ADDRESS 224 Bway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48438

CERTIFICATE OF DEATH

1—PLACE OF DEATH
CITY OF BALTIMORE. (No. South Baltimore General Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Stella Dezes

(a) RESIDENCE NO. 1027 Hanover St ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis Dezes

6 DATE OF BIRTH (month, day, and year) 6/1/1870

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	59	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Pete Pantazakos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ??

14 Informant Dan Chandler Dezes
(Address) 1027 S. Hanover St

15 Filed AUG 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-12-29

17 I HEREBY CERTIFY, That I attended deceased from 7/22, 1929, to 8-12, 1929, that I last saw her alive on 8-12, 1929 and that death occurred, on the date stated above, at 2140 P. m.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetic gangrene

(duration) yrs. mos. 33 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes no Date of 8/6/29

Was there an autopsy?

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Rourkaitis M. D.

(Address) South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	8/15/29

20 UNDERTAKER	ADDRESS
George D. Ruth Inc.	Hanford Av.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48439

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48439

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 4-1 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Gajewski

(a) RESIDENCE NO. Elkridge Md ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occ... yrs. mos. 1 ds. How long in U. S., if foreign birth 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Gajewski

6 DATE OF BIRTH (month, day, and year) July 21 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	50		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Palinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Gajewski

(Address) Elkridge Md.

15 Filed Aug 13, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 12 1929, that I last saw h[illegible] alive on Aug 12, 1929 and that death occurred, on the date stated above, at 9 35 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction (Malignancy?) (duration) yrs. mos. 7+ ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Fyfe, M. D.

8/12, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Aug 16 1929
20 UNDERTAKER	ADDRESS
John M Welch	Elkridge

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48440 — 199 — E 48440

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals, 3-5 Ward)

2-FULL NAME Clarence E Dorsey

(a) RESIDENCE NO. 200 S. Eden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Wh	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept-8-1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Marble Worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER James C. Davis

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna Jeny

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Howard Scarborough
(Address) 1318 E. Eastern Ave

Aug 13 1929 — H. HAMPSON JONES, M. D. — Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Fracture of Skull

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date —

Was there an autopsy? Yes

What confirmed diagnosis? (Signed) H. G. Glades, M. D.

19 Aug 19 (Address) 1430 Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Aug 14 1929

20 UNDERTAKER D. A. Frame & Son

ADDRESS 723 Fawn St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48441

CERTIFICATE OF DEATH

66 E 48441

1-PLACE OF DEATH

City of Baltimore: (No. 902 Argyle Ave St. 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Hudson

(a) RESIDENCE NO. 902 Argyle Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No.

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade profession or particular kind of work: Laborer. colo
(b) General nature of industry, business, or establishment in which employed (or employer): Sparrow Point
(c) Name of employer: Co.

9 BIRTHPLACE (city or town) ... (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) ... (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Hudson

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country): Md

14 Informant: Mary Hudson
(Address): Md.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar
Aug 13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 11th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart.

(duration) ... yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. mos. ds.

18 Where was disease contracted If not at place of death? 902 Argyle Ave

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

(Address) Aug 11th 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Snow Hill, Md	Aug 13, 1929
20 UNDERTAKER	ADDRESS 322 N Schroeder St
Mrs. Kate R. Williams	

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGI

...E PLAINLY, WITH UNFADING ... stated EXACTLY. PHYSICIANS sho... state ...SE
...tion should be carefully supplied. AGE should be state... is very
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO...
important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48442 ✓ **E 48442**

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bronical Hosp 4

City of Baltimore: (No. Johns Hopkins Hos St. 34 Ward) 182

2-FULL NAME Emmanuel C. Jett

(a) RESIDENCE NO. 238 S. Bethel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17 1916

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	12	7	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work school b
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Emanuel Jett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Eubank

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Emanuel Jett
(Address) 238 S Bethel St

15 Filed AUG 13 1929 19 C. HAMPSON JONES M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Accidental Drowning
Result Drowning at
Pool of Wolfe St
(duration) yrs. mos. ds. Sudden

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Pool of Wolfe St
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Facts
(Signed) James M Hundley M. D.
(Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Aug 15 1929
UNDERTAKER	ADDRESS
Robert Waldron	1518 Pulaski St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48443

CERTIFICATE OF DEATH

E 48443

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Madison Ave ST 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude S. Fitzgerald

(a) RESIDENCE NO. 1103 Madison Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M.

5a If married, widowed, or divorced (or) WIFE of C.C. Fitzgerald

6 DATE OF BIRTH (month, day, and year) Nov 30, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Streight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louise Lee

(Address) 1103 Madison Ave

15 Filed AUG 4 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11-29

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to Aug 11, 1929.

that I last saw her alive on Aug 10, 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis Chronic

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Heart Prostration

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) H. S. McCard, M. D.

8/13, 1929 (Address) 2006 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 14 1929
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Druid Hill

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 llks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48444

188-103

E 48444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Balto Hosp St. 25-78 Ward)

2-FULL NAME Dorsey Harman

(a) RESIDENCE NO. Mason St Maysville St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Addie Harmon

6 DATE OF BIRTH (month, day, and year) Apr 12-1870

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
59	3	30	29

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Construction
(c) Name of employer none

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Chas Harmon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Augusta Chaine

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Addie Harmon
(Address) Maggie St. Church Ln.

15 Filed ..... 19..... C. HAMPTON JONES, M. D.
Registrar

UG 14 1929

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture base skull
Struck while trying to
cross street & running into
side of automobile (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Church Home 6-4 Roland Terrace

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) F. J. Frame, M. D.

8/14, 1929 (Address) 2939 W. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 8/14 1929

20 UNDERTAKER Geo L. Schwob

ADDRESS 2101 Fed Ave.

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 48445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 E 48445

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1708 (St.) Monterey Ave (WARD) 25-22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George S. Goodrich

(a) RESIDENCE NO. 1708 (St.) Monterey Ave (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Anna L. Goodrich

6 DATE OF BIRTH (month, day, and year): Apr 19th 1855

7 AGE: Years 74 Months 3 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer worker

(b) General nature of industry, business, or establishment in which employed (or employer): retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John L Goodrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Isabella Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Anna L Goodrich (Address) 1708 Monterey Ave.

15 Filed 8 1929. 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5th, 1929, to Aug 12, 1929, that I last saw him alive on Aug. 12, 1929, and that death occurred, on the date stated above, at 5.40 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Lip
2 Metastases.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec. 1928.

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Strauss, M. D.

8/12, 1929 (Address) 1918 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Aug 15th 1929

20 UNDERTAKER: John J Cowan & Son — ADDRESS: Gorsuch Ln

...ATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write ...CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-...TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 48446

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 19-29

CITY OF BALTIMORE: (No. ——— ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank G. Potter.

(a) RESIDENCE NO. 222 S. Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cutter & trimmer. Jb

(b) General nature of industry, business, or establishment in which employed (or employer) Umbrella Manufacturer.

(c) Name of employer

9 BIRTHPLACE (city or town) Boston, Mass.
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 8, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1929, to August 8, 1929, that I last saw him alive on August 8, 1929, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta & aneurysm.
Myocarditis, chronic and acute

(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab., X-ray, Path.

(Signed) Harvey W. McCleave, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
UNIVERSITY OF MARYLAND	AUG 12 1929
20 UNDERTAKER	ADDRESS
Commissioner Health	

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48447

CERTIFICATE OF DEATH

90 E 48447

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 14-20 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Louise Johnson.

(a) RESIDENCE NO. 1634 Division St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown.

PARENTS

10 NAME OF FATHER James Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Records Baltimore City
(Address) Hospitals.

15 Filed AUG 14 1920 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1920.

17 I HEREBY CERTIFY, That I attended deceased from October 24, 1918, to August 7, 1920,

that I last saw her alive on August 7, 1920,

and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.
Acute cardiac dilatation. (2 hrs)

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & hypertension

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross & microscopic.

(Signed) Marvin M. McClean M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL AUG 13 1920

20 UNDERTAKER Dept. of Health

ADDRESS

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48448

CERTIFICATE OF DEATH

113 E 48448

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 537 Monroe St. 14-20 Ward)

2-FULL NAME Aquilla Dickerson

(a) RESIDENCE NO. 537 Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in rity or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Sing'l

3a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Mar 19-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in whirh employed (or employer) 6 mo
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thos Dickerson

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Alberta Owens

13 BIRTHPLACE OF MOTHER (rity or town) Pa
(State or rountry)

14 Informant Alberta Dickerson
(Address) 537 Monroe

15 Filed AUG 14 1929 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 192 9

17 I HEREBY CERTIFY, That I took charge of the remains desrribed above, held an Inquest (Inquest, autopsy, or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased rame to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test ronfirmed diagnosis? Regular

(Signed) H. Leslie Smith, M. D. Coroner

Aug 13, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Acridental, Suirldal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 14 29
20 UNDERTAKER Samuel Wensley	ADDRESS 518 N Bridle

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-26—A Co.—200 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48449

REGISTERED NO. E 48449

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. 19-46 St. Ward

2-FULL NAME William Livingston.

(a) RESIDENCE NO. 843 W. 33rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 7 mos. 5 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	DIVORCED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Livingston

6 DATE OF BIRTH (month, day, and year) Feb 28 1883

7 AGE	Years	Months	Days
	46	5	15

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.

(State or country)

PARENTS

10 NAME OF FATHER Harry E Livingston

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Mary C Granger

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Mary C Harmon

(Address) 1438 Catalpa Ave Brooklyn Md

15 Filed ..... 19 ..... Registrar

1929 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13-1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest or inquiry.) thereon and from the evidence obtained by said (Inquest or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease Hypertension

Myocarditis

(durration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Appendicitis

(durration) yrs. mos. 6 ds.

(Signed) C. E. Slade M. D.

(Address) 1431 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial Aug 16, 29

20 UNDERTAKER J. F. Denny ADDRESS 715 L. St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48450

E 48450

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2616 W. Fairmount Av ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia E. Helk

(a) RESIDENCE NO. 2616 W Fairmount Av ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 3 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry W. Helk

6 DATE OF BIRTH (month, day, and year) April 30 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Berger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ziegler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Harry W. Helk
(Address) 2616 Fairmount Ave

15 Filed AUG 14 1929 HARRY JONES M. D.
Registrar

G 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1929

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1929, to August 13, 1929, that I last saw her alive on August 12, 1929 and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) — yrs. — about 14 mos.

CONTRIBUTORY (Secondary) Chronic valvular heart disease & Chr. interstitial nephritis (duration) — yrs. — mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirm[illegible] diagnosis? Clinical tests.

(Signed) Henry C. Ohle M. D.

8-13, 1929 (Address) 1203 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 15 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48451

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48451

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH John F. Hopkins Hospital

City of Baltimore: (No. ~~426 N. Bradford~~ 10 St., _____ Ward)

2-FULL NAME John L Kendall

(a) RESIDENCE NO. 426 N Bradford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of the Late Theresa Kendall

6 DATE OF BIRTH (month, day, and year) Dec 28-1886

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
42	7	15	14

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labour.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John T. Kendall

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Boyer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Kate Boyer
(Address) 5 E. Mulberry St

15 Filed _____ 19__ C. HAMPSON JONES, M. D. Registrar
Per _____

G 1 4 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Exam

(Signed) W. G. Clark M. D.

19 (Address) 436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Harford Road	Aug 6 1929

20 UNDERTAKER Wm C. Miller & Son ADDRESS 2337 Jeff St

tion should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 48452 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48452

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2934 Sylvan Ave (Ward) 27-43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Brown

(a) RESIDENCE No. 2934 Sylvan Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	W	widowed

5a If ~~married, widowed, or divorced~~ (or) WIFE of late Alf. J. Brown

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Mairs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Milton Miller

(Address) 2934 Sylvan Ave

15 Filed AUG 14 1929, 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1929, to Aug 13, 1929, that I last saw h[illegible] alive on Aug 13, 1929, and that death occurred, on the date stated above, at 2.45 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs 4 mos 2 ds.

CONTRIBUTORY (Secondary) Myocarditis Auricular fibrillation (duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. P. MacMurchy, M.D.

, 19 (Address) 2147 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood — DATE OF BURIAL: Aug 16 1929

UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48453

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48453

CERTIFICATE OF DEATH

1-PLACE OF DEATH West Baltimore General ST. 2100 W'ARD 118

CITY OF BALTIMORE: (No.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Florence Hunt

(a) RESIDENCE NO. 6217 Hartford Rd ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs mos 5 ds (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married.

5a If married, widowed, or divorced (a) HUSBAND of (or) WIFE of: Walter C Hunt

6 DATE OF BIRTH (month, day, and year): Oct. 1, 1892

7 AGE — Years: 36 . Months: 10 Days: 11 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto. Md.

PARENTS
10 NAME OF FATHER: Joseph Fuller.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.
12 MAIDEN NAME OF MOTHER: Mary Stokes
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge, Md.

14 Informant: Walter C
(Address)

Filed AUG 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 12, 29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1929, to Aug. 12, 1929, that I last saw h[illegible] alive on Aug 12, 1929, and that death occurred, on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH* was as follows:
Mechanical obstruction of intestine with Perforation
(duration) yrs mos 3 ds
CONTRIBUTORY (Secondary): Shock. (duration) yrs mos 4 hrs.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 8/6/29
Was there an autopsy? yes!
What test confirmed diagnosis? Clinical and Autopsy

(Signed) J Kastagna M. D.
8/12 1929 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: Aug 15 1929

20 UNDERTAKER: H. H. Cook — ADDRESS: 1217 Ford St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

48454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48454

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 5-E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Stewart

(a) RESIDENCE NO. 537 Aisquith ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	43	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pick & Shovel laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) South Carolina.

PARENTS

10 NAME OF FATHER Rozz Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Carrie Crawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Records Baltimore City Hospitals
(Address)

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to August 9, 1929, that I last saw him alive on August 9, 1929, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic interstitial.
Myocarditis, chronic and acute

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Hypertension (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab: Cystoscopic Exam.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

JUN 14 1929

AUG 1 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 48455

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 111-20 Ward)

2-FULL NAME Luther Johnson

(a) RESIDENCE NO. 502 Hoon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mame L. Johnson

6 DATE OF BIRTH (month, day, and year): Apr 8 1879

7 AGE: Years 50 Months 4 Days 3 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Attorney Engrossing 030
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Ella Williams

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mame L. Johnson
(Address) 502 Hoon

15 Filed Aug 14 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Fred Leich, M. D. Coroner

(Address) Aug 12/29

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Aug 14, 29

20 UNDERTAKER: Edward M. Fulton — ADDRESS 2325 Madison Av.

be stated EXACTLY.' PHYSICIANS should state CAUSE
tion should be carefully supplied. AGE should be st
OF DEATH in plain terms, so that it may be prope
important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

227706
E 48456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38
E 48456

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Allen

(a) RESIDENCE NO. 11 N. Castle St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy

6 DATE OF BIRTH (month, day, and year) 8-15-00

7 AGE 28 Years 29 Months 11 Days 24 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Br. West Indies

PARENTS

10 NAME OF FATHER Wm

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Eliz Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 14 1929 C. HAMPSON JONES, M. D. Registrar

3831

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9-1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug 9, 1929, that I last saw him alive on Aug 9 '29, 1929 and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Luetic Heart Disease
Myocardial Insufficiency
Pericarditis

(duration) yrs. 2 mos. (?) ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Ralph Ellsworth M.D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner of Health

AUG 14 1929

Property taxable. Leave all items, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48457

CERTIFICATE OF DEATH.

E 48457

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 S. Bentalou St., 46-69 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Frey Frei

(a) RESIDENCE No. 503 S. Bentalou ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Julia Frei

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Julia Frei (Address) 503 S. Bentalou St.

15 Filed AUG 14 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/12 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/4 1928 to 8/12 1929, that I last saw him alive on 8/12 1929, and that death occurred, on the date stated above, at 11:59 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Welk, M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem.	Aug 15, 1929
20 UNDERTAKER Charles W. Dill.	ADDRESS 3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Jegges.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48458

CERTIFICATE OF DEATH.

31 E 48458

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1543 E 29 St. 4-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick M Jegges

(a) RESIDENCE NO. 1543 E 29 St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1899 Aug 21 1899

7 AGE: Years 29 Months 11 Days 9 22 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John F Jegges

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Catherine [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Catherine Jegges 1543 E 29

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

G 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 13, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11 , 1928 , to Aug 13th , 1929 , that I last saw him alive on Aug 12th , 1929 , and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden M. D.

(Address) 1216 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood — DATE OF BURIAL: Aug 16 29

20 UNDERTAKER: John Welsh — ADDRESS: 202 Fulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48459 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48459

CERTIFICATE OF DEATH.

+ 118-002

28-65

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Ferguson

(a) RESIDENCE No. Kernan Drive-Windsor Tinace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Lottie L. Ferguson

6 DATE OF BIRTH (month, day, and year) November 22, 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	8	21 22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Brigham-Hopkins

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George F. Ferguson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Meise

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Lottie Ferguson
(Address) Kernan Drive-Windsor Ter

15 Filed AUG 14 1929, 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-4, 19 29, to 8-13, 19 29,

that I last saw h~~im~~ alive on 8-13, 19 29,

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction & peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-5-29

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George Brunner, M. D.

(Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug 16 1929

20 UNDERTAKER: Oct 15 Cook — ADDRESS: 1003 West Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48460

CERTIFICATE OF DEATH

E 48460

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 Winans Way, ST. 28-65 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Thomas Thompson, Jr.

(a) RESIDENCE NO. 618 Winans Way ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. Government, Washington, D.C.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John T. Thompson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Allison D. Dolphin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. J. Gerhard Lampe
(Address) 618 Winans Way

15 Filed AUG 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to Aug 13, 1929, that I last saw him alive on Aug 12, 1929 and that death occurred, on the date stated above, at 10.45 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 6m mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Lampasis, M. D.

8/14, 1929 (Address) 3409 Calloway Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug. 16, 1929
20 UNDERTAKER H. B. Cook	ADDRESS 1003 West Baltimore St.

IMPORTANT—Fill in plain terms, so that it may be properly understood. Erasures, interlineations, etc., may cause certificate to be refused. See instructions on back of certificates.

Cor.—12-5-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-223

E 48461 1-PLACE OF DEATH

E 48461 REGISTERED NO.

City of BALTIMORE: (No. 2031 Hollins St. 20-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Franklin Crawford

(a) RESIDENCE NO. 2031 Hollins St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M. Crawford

6 DATE OF BIRTH (month, day, and year) April 18, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	77	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore & Ohio R.R.

9 BIRTHPLACE (city or town) Montgomery County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Hamilton Crawford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mr. Milton H. Crawford

(Address) 2031 Hollins St.

15 Filed C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 11 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) and that said deceased came to him death in the day stated above.

THE CAUSE OF DEATH was as follows:

Fract Jaw — due to being thrown from auto when it collided with another

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic Tremors

(Duration) yrs. mos. ds.

(Signed) G. J. Frame M. D.

(Coroner)

8/13 1929 (Address) 2939 McElderry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? ~ E. Fort & Patrick Rd. Fells Pt.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Aug. 14 1929

20 UNDERTAKER Sept 2 Cook ADDRESS 1003 W. Baltimore St

8-14-1929

GIVE PLACE, WITH EXACT LOCATION—THIS IS A LEGAL RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48462

CERTIFICATE OF DEATH

90

E 48462

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3701 N. Charles ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Donnelly

(a) RESIDENCE NO. 3701 N. Charles ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Regina Landers

6 DATE OF BIRTH (month, day, and year) June 21, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pike County
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Donnelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Drake

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Chas. J. Landers
(Address) 3701 N. Charles St.

15 Filed 1 4 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to August 13, 1929, that I last saw h alive on August 13, 1929 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis, Aortic insufficiency, Arteriosclerosis.

1 (duration) yrs mos. ds.

CONTRIBUTORY (Secondary) Myocardial decompensation.

(duration) yrs mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benjamin N. Rutledge M. D.

, 19 (Address) 1205 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/17 19 29
20 UNDERTAKER Henry H. Myers & Son	ADDRESS 805 N. Calvert

IMPORTANT. See instructions on back of certificates. Be sure to fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION of very

Spec.—2-29-28—L. F. S.—500 Blks.

(Florence B. Enson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48463

CERTIFICATE OF DEATH

129

E 48463

1—PLACE OF DEATH

REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME (Florence B. Enson)

(a) RESIDENCE NO. 5807 Falls Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 4 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Ed. Enson

6 DATE OF BIRTH (month, day, and year) 1889 Dec 31

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General natore of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt (State or country) Md

PARENTS

10 NAME OF FATHER Henry DeBus

11 BIRTHPLACE OF FATHER (city or town) Balt (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Hoover

13 BIRTHPLACE OF MOTHER (city or town) Balt Co (State or country) Md

14 Informant Chas E. Enson

(Address) 5807 Falls Road

15 Dated AUG 14 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929 Aug 13

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to Aug 13, 1929, that I last saw her alive on Aug 13, 1929 and that death occurred, on the date stated above, at 9.55 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Primary Contracted Kidney

(Signed) Jesse S. Fogel, M. D.

, 19 (Address) U. M. H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Hill Balto	Aug 16 1929
20 UNDERTAKER	ADDRESS
Ehinowith Son	3615 Chestnut Ave

AUG 14 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Rose Billups

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 48464

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48464

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 W Lrs St) (ST.) D 2-30 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Billups

(a) RESIDENCE. NO. 638 W Lrs St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William V. Billups

6 DATE OF BIRTH (month, day, and year) May — 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William V Billups

(Address) 638 W. Lrs St

15 Filed AUG 15 1929 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1929

17 I HEREBY CERTIFY, That I attended deceased from July 4 1929, to Aug 13 1929, that I last saw h alive on Aug 12 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease Collapse

(duration) 1 yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) 1 yrs. 1 mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptoms

(Signed) Charles W. Fowler, M. D.

Aug 14 1929 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	Aug 16 1929

20 UNDERTAKER E. L. Brown & Son ADDRESS 101 N. Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

176 E 48465

CERTIFICATE OF DEATH

E 48465

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3224 Ellerslie ave ST. 9-46 WARD)

2—FULL NAME Ann Virginia Magness

(a) RESIDENCE NO. 3224 Ellerslie ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Laurence R Magness

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mabel E. Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Laurence R. Magness

(Address) 3224 Ellerslie ave

15 Filed AUG 15 1929 (19) H. HANSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1929, to Aug 14th, 1929.

that I last saw her alive on Aug 12th, 1929

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) not determined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What tests confirmed diagnosis?

(Signed) Thomas H Magness, M. D.

8/15, 1929 (Address) 14 E Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/16 1929
20 UNDERTAKER	ADDRESS
Chas. F. Kraus & Son	1101 Mount Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48466

CERTIFICATE OF DEATH.

E 48466 51

1-PLACE OF DEATH Sinai Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Mead St. 1622 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvin Appelestine

(a) RESIDENCE NO. 1621 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 21 1922

7 AGE Years 6 Months 11 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Samuel Appelstein

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Flora Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Morris Miller (Address) 1621 W. Lanvale

15 Filed AUG 15 1929 CLAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/7 1929 to 8/14 1929, that I last saw h/m alive on 8/14 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Rheumatic Fever
Rheumatic Endocarditis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Macroscopic & Autopsy

8/14, 1929 (Signed) A. D. Gibson M. D. (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Cem DATE OF BURIAL 8/15 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

22 E 9 48467

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 48467

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Romolo Fiore

(a) RESIDENCE NO. 34 Wheeler ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U. S., If foreign birth 20 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Fiore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 15 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug - 13 - 29

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1929, to Aug 13, 1929, that I last saw him alive on Aug 13, 1929 and that death occurred, on the date stated above, at 9 1/4 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, pericard + Cerebral Hypertension -

Cardiac Hypertrophy + insufficiency - appr (symptoms)

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchitis ? pneum -

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes -

What test confirmed diagnosis? —

(Signed) Fred W. Sack, M. D.

19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 8/16/29

20 UNDERTAKER George D. Roth & Son

ADDRESS 1735 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48468 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-001 E 48468

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sydenham Hospital 7-13 (STREET) (WARD)

2—FULL NAME JACOB COLBERT.

(a) RESIDENCE NO. 1707 E. Eager St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hopewell Va

PARENTS

10 NAME OF FATHER Jacob Colbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Helen Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Jacob Colbert

(Address) 1707 E. Eager St —

15 Filed AUG 15 1929 19 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from August 14. 1929. to August 14. 1929.

that I last saw him alive on August 14 1929

and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Diphtheritic Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1707 E. Eager St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Derby M. D.

8-14 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary cemetery	Aug 15 1929

20 UNDERTAKER [redacted] Elliott ADDRESS 1725 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48469
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. ST., 3-4 WARD)

2—FULL NAME Raymond Jackson

(a) RESIDENCE NO. 1515 E. Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed ....., 19 .... Registrar

HAMPSON JONES, M. D.

AUG 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/12/29

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1929, to 8/12, 1929, that I last saw him alive on 8/12, 1929 and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Urinary extravasation
of abdominal wall,
urinary retention, urethral
strictures (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis, edema
lungs (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 8/9/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. U. Lumpkin, M. D.

8/13, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Aug 15 1929
20 UNDERTAKER	ADDRESS
Ida. Snowden	1708 Madison

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48470 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48470

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2040 Harford ave ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Kreitman

(a) RESIDENCE NO. 2040 Harford ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 10 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis P. Kreitman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christianna Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Bessie Kreitman

(Address) 2040 Harford ave

15 Filed AUG 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/2, 19 29, to 8/14, 19 29, that I last saw h[er] alive on 8/14, 19 29 and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Uremic furious & coma

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jay D Prowell, M. D.

19 (Address) 1623 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 16th 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	426 E Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48471

CERTIFICATE OF DEATH

129

E 48471

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3605 Parkside Drive ST. 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose M. Koska

(a) RESIDENCE NO. 3605 Parkside Drive ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph J. Koska

6 DATE OF BIRTH (month, day, and year) July 13, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	0	30 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Louise Meise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Joseph J. Koska
(Address) 3605 Parkside Drive

15 Filed AUG 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1 19 29 to Aug 11 19 29

that I last saw ... alive on Aug 11 19 29

and that death occurred, on the date stated above, at 9,15 P. M.

The CAUSE OF DEATH* was as follows: Apoplexy, Hypertension

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Philip Henrig M. D.

8/14/29 (Address) 2016 Orleans St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem.

DATE OF BURIAL Aug. 16/ 19 29

20 UNDERTAKER Philip Henrig

ADDRESS 2016 Orleans St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 48472

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balt. City Hosp. ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Schaeffer

(a) RESIDENCE NO. 919 Riggs Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Western Md Lumber Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Schaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed AUG 15 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/29

17 I HEREBY CERTIFY, That I attended deceased from 6/13, 1929, to 8/14, 1929, that I last saw h[illegible] alive on 8/13, 1929 and that death occurred, on the date stated above, at 12 [illegible] P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of inguinal glands bilateral

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Cystitis, Pyelo-nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lungstrom, M. D.

8/14, 1929 (Address) Balt City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Siloam, Westminster

DATE OF BURIAL 8/16 1929

20 UNDERTAKER Geo. W. Cook

ADDRESS 1274 Pennsylvania Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 48473

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48473

CERTIFICATE OF DEATH

X 38

1—PLACE OF DEATH

REGISTERED NO. 12-49

CITY OF BALTIMORE, (No. Union Memorial Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Roger B Broome

(a) RESIDENCE NO. Carvel Beach Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roger B Broome

6 DATE OF BIRTH (month, day, and year) Aug 10 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown Md
(State or country)

PARENTS

10 NAME OF FATHER Michael L. Cunningham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Elizabeth Eyler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hagerstown Md

14 Informant Husband
(Address) Carvel Beach, Md

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1929, to Aug 14, 1929, that I last saw h[illegible] alive on Aug 14, 1929 and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Inner - Cause unexplained

(duration) 0 yrs. 0 mos. 20 ds.

CONTRIBUTORY (Secondary) General Sepsis, Chronic cardiac disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Carvel Beach Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Jesse E Foster, M. D.

19 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	8/16 1929
20 UNDERTAKER H. M. Cook	ADDRESS 1217 Druid Pk

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 19 1929 HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48474

CERTIFICATE OF DEATH

44 E 48474

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 N. Brice ST. 16-2K WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna D. Wolf.

(a) RESIDENCE NO. 812 N. Brice ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Wht	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Wolf.

6 DATE OF BIRTH (month, day, and year) Oct 1. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John H. Voegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Asmus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Jessie L. Reed

(Address) 1508 Harman Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13. 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1929, to Aug 13, 1929, that I last saw h.r alive on Aug 13, 1929 and that death occurred, on the date stated above, at 5,30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Chronic Myocarditis) 1 y

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

Autopsy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) J. Thomas Hutson, M. D.

, 19 (Address) 1001 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 8/16/29

20 UNDERTAKER W. H. Cook. — ADDRESS 1217 E. Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48475

CERTIFICATE OF DEATH.

90 E 48475

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2821 Woodbrook ST. 13-54 WARD)

2-FULL NAME Mary J. Singerman

(a) RESIDENCE No. 2821 Woodbrook ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard L Singerman

6 DATE OF BIRTH (month, day, and year): Aug 23-1867

7 AGE: 61 Years 62 | Months 11 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Jane Fitchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Bernard Singerman (Address) 2821 Woodbrook

15 Filed AUG 15 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/13 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/11, 1929, to 8/13, 1929, that I last saw h alive on 8/13, 1929, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ? yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 2821 Woodbrook Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack. H. Wolman, M. D.

8/14 1929 (Address) 6-E-Peach St Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Aug 16 1929

20 UNDERTAKER: Jos J Weinstein — ADDRESS: 15 E Lafayette

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48476

CERTIFICATE OF DEATH

129 E 48476

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 Hollins ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Warr

(a) RESIDENCE NO. 1412 Hollins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 21-1881

7 AGE	Years	Months	Days 27	If LESS than 1 day, ...hrs. or ....min.
	47	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Machine Shop

(c) Name of employer: B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Joseph H. Warr

(Address): 1412 Hollins St

15 Filed: AUG 15 1929 H. McCOY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14-1929

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1929, to August 14, 1929

that I last saw h[illegible] alive on August 14, 1929

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Dropsy & Cardiac Insufficiency (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stafford Davis, M. D.

, 19 (Address) 7-7 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 16 1929
20 UNDERTAKER	**ADDRESS**
George E Smith	Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48477

CERTIFICATE OF DEATH

74-001

E 48477

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. — ST. 23-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Junkewitz

(a) RESIDENCE NO. 42 E. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Katie Junkewitz.

6 DATE OF BIRTH (month, day, and year) Dec. 20. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Records.

(Address) Baltimore City Hospitals.

15 Filed ..... 19 ..... Registrar

AUG 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13, 1929.

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1929. to August 13. 1929.

that I last saw h. alive on August 13, 1929.

and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum - not traumatic

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. Lab. History.

(Signed) Marvin M. McLean M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Aug. 16 1929
20 UNDERTAKER Margaret A. Glynn	ADDRESS 1422 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 48478

E 48478

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 509 Hanover St. 12-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Simmons

(a) RESIDENCE NO. 509 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): May 26, 1843

7 AGE: Years 86 | Months 2 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Charles Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Mary Myers
(Address) 1911 Bigg Ave

15 Filed ..... 19 ..... HARRY JONES, M. D. Registrar

AUG 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Aug 13, 1929, that I last saw her alive on Aug. 8, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) H. S. Smith, M. D.

Aug. 14 1929 (Address) 129 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 15, 1929
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	422 High St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48479

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

REGISTERED No. E 48479

CITY OF BALTIMORE (No. 2734 Alameda St., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Chenworth Frances

(a) RESIDENCE NO. 2734 Alameda ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edenia Frances

6 DATE OF BIRTH (month, day, and year): July 13 1827

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	102	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md.

PARENTS

10 NAME OF FATHER: Thomas Frances

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md

12 MAIDEN NAME OF MOTHER: Priscilla Chenworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Edenia Standiford

(Address) 2734 Alameda

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 13-1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1916, to Aug 12, 1929.

that I last saw h.. alive on Aug 10, 1929

and that death occurred, on the date stated above, at 11.50 A. M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) A. Dodge Lear M. D.

8/15, 19.. (Address) 705 Mes. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Wash'n Chapel	Aug 15 1929
20 UNDERTAKER: H. P. Hickman Sons	ADDRESS: North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48480

228080.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 16-002

E 48480

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert L. McLarin

(a) RESIDENCE NO. 1747 Mullikin ST., WARD Alabama

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 wks How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/21/29

7 AGE: Years | Months: 6 | Days: 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER John McClarin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Carrie Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 14, 1929

that I last saw him alive on Aug 14, 1929

and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bacillary)

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Fred W. Geib, M. D.

8/15, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem.

DATE OF BURIAL: Aug 15 1929

20 UNDERTAKER: Mrs J. G. Locks

ADDRESS 1302 Ft

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 15 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 48481

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-801

E 48481

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

REGISTERED NO. 17-26

CITY OF BALTIMORE: (No. Saubard & Green ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thersa Rayner

(a) RESIDENCE NO. 660 W. Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25-29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Edwin E Rayner

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Pauline V Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Edwin Rayner
(Address) 660 W Franklin

15 Filed DEC 15 1929, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929, to Aug 15, 1929, that I last saw her alive on Aug 15, 1929, and that death occurred, on the date stated above, at 1:10 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) Walter B. Johnson, M. D.

Aug. 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 16 1929
20 UNDERTAKER W M Roulson	ADDRESS 2228 W Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Blum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48482

CERTIFICATE OF DEATH

49

REGISTERED No. D 48482

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital DIST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Blum

(a) RESIDENCE NO. 437 N. Lakewood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	W White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Blum

6 DATE OF BIRTH (month, day, and year) April 15, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Shipbuilding

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Charlotte Blum (Wife)

(Address) 437 N. Lakewood Ave

15 Filed AUG 15 1929 19 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/29

17 I HEREBY CERTIFY, That I attended deceased from 8/8/29, 19..., to 8/14/29, 19..., that I last saw h... alive on 8/14/29, 19..., and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervical lymph nodes

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/12/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) St Joseph Hospital, M. D.

, 19 (Address) B Hendrix M.D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 17 1929
20 UNDERTAKER Henry Sander & Sons Inc	ADDRESS Baltimore St & Broadway

IMPORTANT—Physician should fill out every applicable item. Write plainly. Use ink. Do not abbreviate. Cause of death must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 48483

1—PLACE OF DEATH — REGISTERED NO. E 48483

CITY OF BALTIMORE: (No. 1304 ½ Highland ave No-1 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby (Foetus? Boy Lynch

(a) RESIDENCE NO. 1304 ½ Highland ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 11 min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of indastry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER William Lynch.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York ny

12 MAIDEN NAME OF MOTHER Christina Bryant

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Aberdeen Md.

14 Informant William Lynch.

(Address) 1304 ½ Highland ave

15 Filed AUG 15 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 15-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 15, 1929,

that I last saw h.im alive on Aug 15, 1929.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Breech (Nephritic).

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dudley P Bowe, M. D.

8/15. 1929 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Aug 15 1929
20 UNDERTAKER George W. Zibler	ADDRESS 1737 E Eager st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 48484

REGISTERED NO.

1—PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 30-71 ST... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. Harry E. Knipp

(a) RESIDENCE NO. 4025 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Harry E. Knipp

6 DATE OF BIRTH (month, day, and year) Oct 24, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Knipp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Caroline Bonacieu

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Record

(Address)

15 Filed AUG 15 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8th, 1929, to Aug 14, 1929, that I last saw him alive on Aug. 14, 1929, and that death occurred, on the date stated above, at 3.06 A m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure and Surgical shock (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 8/10/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr. A. Thompkins M. D.

, 19 (Address) Mer Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 16 1929
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Son	Mt Calvert

information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48485

CERTIFICATE OF DEATH

70 ✓ E 48485

1—PLACE OF DEATH St. Joseph Hosp — REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline ST., 26-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Lutz

(a) RESIDENCE NO. 4516 Hamilton ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Almira Lutz

6 DATE OF BIRTH (month, day, and year) June 20th 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Paul C. Lutz

11 BIRTHPLACE OF FATHER (city or town) Decrosa (State or country) Wisconsin

12 MAIDEN NAME OF MOTHER Laura S. Bussey

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Maryland

14 Informant Almira Lutz (Address) 4520 Hamilton Ave.

15 Filed ____, 19__ C. HAMPSON JONES, M. D. Registrar

Per ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1929, to Aug 17, 1929, that I last saw him alive on Aug 14, 1929 and that death occurred, on the date stated above, at 9 20 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Encephalitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 14/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C. H. Bauernschmidt, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug 17 1929
20 UNDERTAKER	ADDRESS
Frederick Sasse & Co.	Fullerton

G 15 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-01

E 48486

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. [illegible] Ward)

2-FULL NAME Elmer D. Walker

(a) RESIDENCE NO. 3207 Frost St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Tillie Walker

6 DATE OF BIRTH (month, day, and year) June 5 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	34	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Acetylene
(b) General nature of industry, business, or establishment in which employed (or employer) Burner
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Walker

11 BIRTHPLACE OF FATHER (city or town) Indiana
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Kirsch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mr. Jas Walker
(Address) 3207 Frost St

Filed ... 19... C. HAMPSON JONES, M. D. Registrar

Dat[illegible] Balto

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

C.R.Steam acc.
Traumatic Amputation
Both Legs

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. 6 hrs.

(duration) yrs. mos. 1 hr.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Date of Aug 10/29

Was there an autopsy? No

What test confirmed diagnosis? Was also [illegible] Staden

(Signed) [illegible], M. D.

, 19... (Address) 1436 Perry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL 8/16 1929

20 UNDERTAKER J. A. Moran ADDRESS 300 E Balto.

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 15 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 48487

22926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 48487

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL St. 4-30 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther Shawder

(a) RESIDENCE NO. 1501 Argyle Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	black	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work "Servce"

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Irvine Freed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Celia Jasper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Nurse

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 15 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-14-29

17 I HEREBY CERTIFY, That I attended deceased from 7-25-, 1929 to 8-14-, 1929.

that I last saw her alive on 8-14-, 1929

and that death occurred, on the date stated above, at 10 20 a. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - Adenoma of Hypophysis (Cerebri)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 27, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence C Gardner Jr. M. D.

8/15. 1929 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mayfield 9 Va.	8/16
20 UNDERTAKER	ADDRESS
Gen. W. Chase & Son	1400 Hoffman

UG 15 1929

Information should be carefully supplied. Age should be stated. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48488

CERTIFICATE OF DEATH

90 E 48488

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 531 N. Stricker St. 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bettie Horton Gaines Scott

(a) RESIDENCE NO. 1531 N. Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20/1876

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	53	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home (Domestic)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Franklin, Va

PARENTS

10 NAME OF FATHER (?) Horton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va (?)

12 MAIDEN NAME OF MOTHER Frances Hurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Pearl Gaines Cleaves
(Address) 1620 Westwood Ave

15 Filed AUG 15 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13-29

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1929, to Aug 13, 1929.

that I last saw h.er alive on Aug 12, 1929

and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. D. Tuglee, M. D.

Aug 13, 1929 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8-15 1929
20 UNDERTAKER	ADDRESS
Daniel Eaton	916 N Ave

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. PHYSICIANS should fill in and sign CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48489

CERTIFICATE OF DEATH

90 E 48489

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1718 Hull St. (ST.) 24-35 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laurence J. Clark

(a) RESIDENCE NO. 1718 Hull ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): July 7, 1914

7 AGE: Years 15 | Months 1 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: James Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Cardea

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jas. Clark

(Address): 1718 Hull St

15 Filed AUG 15 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 13. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 29, to Aug 13, 19 29

that I last saw him alive on Aug 13, 19 29

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) & Mitral regurgitation hypertrophy of the heart

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. F. Mac Murphy M. D.

Aug 15. 1929 (Address) 214 Hunter Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery | DATE OF BURIAL: Aug. 16 19 29

20 UNDERTAKER: Margaret E. Flynn | ADDRESS: 1412 Pigtail St.

AUG 15 1929

Before state ... Every ... should be stated EXACTLY. PHYSICIANS should state ... be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48490

CERTIFICATE OF DEATH

129 ✓ E 48490

1—PLACE OF DEATH

REGISTERED NO. 20-98

CITY OF BALTIMORE: (No. 3061 Frederick Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME W. Bernard Linthicum

(a) RESIDENCE NO. 3061 Frederick Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Linthicum

6 DATE OF BIRTH (month, day, and year) March 12, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Professor

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. Charles Linthicum

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. May J. Gisiner
(Address) 3061 Frederick Ave.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

G 15 1929 April

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to August 14, 1929,

that I last saw him alive on August 13, 1929,

and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

with Edema

(duration) 29 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab.

(Signed) S. Lloyd Johnson M. D.

8/14, 1929 (Address) Augusta and Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug. 16, 1929
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 West Baltimore St

INFORMATION should be carefully supplied. ALL ITEMS should be filled in. CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48491 E 48491

CERTIFICATE OF DEATH.

161-08

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 75-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl O'Brien

(a) RESIDENCE No. 2 Holmhurst Ave ST. Catonsville WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 4, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward B. O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth M. Tillett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Edna O'Brien (Address) 2 Holmhurst Ave

15 C. HAMPSON JONES, M. D. Registrar

G 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-4, 19 29, to 8-14, 19 29

that I last saw h[illegible] alive on 8 14, 19 29,

and that death occurred, on the date stated above, at 9.40 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

5/14 19 29 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Aug. 16, 19 29

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 W. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48492

CERTIFICATE OF DEATH.

9ZE 48492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital S. 40 St. Ward)

2-FULL NAME Gov. Karl

(a) RESIDENCE NO. 3015 Bel air Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillian Karl

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 60 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Gov Karl

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: W. E. Jones

(Address): 3013 Bells Rd

Filed AUG 15 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13-29 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Aug 15 1929 (Date signed) Kelly (Coroner) M. D.

(Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) Farmer

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial: aug 17 1929

20 UNDERTAKER: Frank V. Pepitone ADDRESS: 2414 E Baltimore

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr. Houk - Tbc + Appleton

E 48493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

#6 E 48493

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 N. Pulaski ST. 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nettie A. Harris

(a) RESIDENCE NO. 2108 N. Pulaski ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E.

6 DATE OF BIRTH (month, day, and year) Oct. 11 1883

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER A. Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Carrie Gurtz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Harris

(Address) 2108 N. Pulaski.

15 Filed AUG 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 19 29, to Aug 7 19 29.

that I last saw h alive on Aug 7 19 29

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) mo. ds.

CONTRIBUTORY (Secondary) Cardiac Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) H. C. Houk, M. D.

Aug. 15 1929 (Address) 1 W. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: 8/16 1929

20 UNDERTAKER: Wilkinson Bros — ADDRESS: 122 W. Saratoga

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

AUG 15 1929

Spec. 6-9-19—H. P. Co.—1000 Blks.

E 48494

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48494

CERTIFICATE OF DEATH.

89

REGISTERED No

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 917 Dukeland ST. 16-6 WARD

2-FULL NAME Ernst Robert Schneider

(a) RESIDENCE No 917 Dukeland ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Schneider

6 DATE OF BIRTH (month, day, and year) Dec. 22-1860

7 AGE Years 68 Months 7 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Bretz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Anna Schneider (Address) 917 Dukeland Ave.

15 Filed AUG 16 1929 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 13 1929 to Aug 13 1929

that I last saw him alive on Aug 13 1929

and that death occurred, on the date stated above, at 1000 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

CONTRIBUTORY (Secondary) (duration) Cardiac failure yrs. 8 mos. 7 ds.

(duration) yrs. mos. 1 d.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy D. McCann M. D.

19 (Address) 400 N. Payson St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery DATE OF BURIAL Aug. 16 1929

20 UNDERTAKER George L. Schwabe ADDRESS 210 Fidk. Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48495 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 | E 48495

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No.) Broadway (St.) Hermand (WARD) 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josephine Riggins

(a) RESIDENCE No. 303 E 27th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mr John Riggins

6 DATE OF BIRTH (month, day, and year) Nov. 5 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crisfield Md

PARENTS

10 NAME OF FATHER John Bunk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Crisfield

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Crisfield Md

14 Informant Mr John Riggins

(Address) 303 E 27th St.

15 Filed AUG 19 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-15 1929

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to Aug 15, 1929,

that I last saw her alive on Aug 15, 1929,

and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hemotomesis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 6-21-29 & 7-29-29

Was there an autopsy? No Yes

What test confirmed diagnosis? Clinical

(Signed) Chas E Wallace M. D.

, 19 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crisfield Md,

DATE OF BURIAL Aug 17 1929

20 UNDERTAKER Charles L. Stevens

ADDRESS 1501 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1624

CERTIFICATE OF DEATH

E 48496

REGISTERED NO. E 48496

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Clement ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Youngmann

(a) RESIDENCE NO. 1403 E Clement ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 13. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Henry Youngmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Catherine Blumenschein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

PARENTS

14 Informant Mrs Catherine Youngmann

(Address) 1403 E Clement St

15 Filed AUG 16 1929 Hour 8 A.M. Registrar M. Kerr

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 15 1929

17 I HEREBY CERTIFY, That I attended deceased from aug 12, 1929, to aug 15, 1929

that I last saw h alive on aug 14, 1929

and that death occurred, on the date stated above, at 6 30 p. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) M. L. Campbell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. C.C. Md	aug 16 1929
20 UNDERTAKER	ADDRESS
Charles L. Stevens	1501 E Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

48497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48497

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore (No.) Woods Near Restaurant (Street) Rogers Av. (Ward) 28-65

2-FULL NAME Paul Coble

(a) RESIDENCE NO. 4117 Granada Av. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella Coble

6 DATE OF BIRTH (month, day, and year) Aug 16-1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	36	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) St Thomas
(State or country) Franklin Co. Pa.

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Isabella Coble
(Address) 4117 Granada Av.

15 Filed AUG 15 1929 16 HARRISON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 12th 192 9

17 I HEREBY CERTIFY That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4117 Granada Av.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Regulay Hoblitzell, M. D.

Aug 13th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chambersburg Pa

DATE OF BURIAL 8/17 1929

20 UNDERTAKER W. L. Tickner & Son

ADDRESS Wash. Pa.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Bks.

E 48498

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 48498

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 18-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Nicolai

(a) RESIDENCE NO. 1215 W. Baltimore ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stage Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Theatrical

(c) Name of employer San Carlos Opera Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER ~~Deceased~~ Wm. Nicolai

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Marian Cookes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Louise Peters

(Address) 1215 W. Balto St.

15 Filed AUG 19 1929, 19 [illegible] Registrar

H. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14/29

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1929, to Aug. 14, 1929, that I last saw him alive on August 14, 1929, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Rattenni, M. D.

19 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Removed to Lafayette

DATE OF BURIAL Aug 16, 1929

20 UNDERTAKER Wm. Mup John W. Teufel & Son

ADDRESS 801 Fayette

N. B.—WHITE PENCIL, WITH EXPLANATIONS, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48499

CERTIFICATE OF DEATH.

65-001

E 48499

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 E. 28 St. 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Karnmann

(a) RESIDENCE NO. 320 E. 28th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of Grace M. Karnmann

6 DATE OF BIRTH (month, day, and year) 4/4/1865.

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
64	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail-carrier

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer U. S. Balto., Md.

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Hopewood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick, Md.

14 Informant Mrs. Firestone

(Address) Daughter.

15 Filed AUG 16 1929 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15 1929.

17 I HEREBY CERTIFY, That I attended deceased from 8/1, 1929, to 8/15, 1929, that I last saw him alive on 8/14, 1929; and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma - myelogenous leukemia

(duration) 2 yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Anemia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No - Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory findings.

(Signed) J. W. Symington M. D.

, 19 (Address) 1911 Boone St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Aug 17 1929.

20 UNDERTAKER J. W. Teufel & Son ADDRESS 501 W. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48500

CERTIFICATE OF DEATH

129

E 48500

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE (No. 2422 Guilford Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah A. Todd

(a) RESIDENCE NO. 2422 Guilford Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of: John D. Todd

6 DATE OF BIRTH (month, day, and year): June 22 185[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Sam. N. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Cecilia Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mary Frood (Address) 2422 Guilford Ave

Filed AUG 15 1929, 19 ALBERT JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14 19 29, to Aug. 14 19 29, that I last saw h[illegible] alive on Aug 13 19 29 and that death occurred, on the date stated above, at 1.20 p. m.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

4 yrs 9 mos 23 ds. (duration)

CONTRIBUTORY (Secondary)

54 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. J. Cotton M. D.

Aug 14, 19 29 (Address) 2424 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Stample	Aug 16 19 29
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Falls Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48501

CERTIFICATE OF DEATH

90 E 48501

1—PLACE OF DEATH

REGISTERED NO. 27-46

CITY OF BALTIMORE (No. 5306 York Rd ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Samuel Parr

(a) RESIDENCE NO. 5306 York Rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie F. Parr

6 DATE OF BIRTH (month, day, and year) 4/8/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) White Hall Md.

PARENTS

10 NAME OF FATHER Jacob J. Parr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Ann Sponseller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Dr. N. D. Parr (Address) 1218 W. Fayette St

15 Filed ....., 19.... C. HAMILTON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 5th, 1929, to Aug 14, 1929, that I last saw h... alive on Aug 14, 1929, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema & Dyspnea

(duration) 2 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) W. E. Fridgen Jr. M. D.

, 19 (Address) 1013 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Aug. 16 1929
20 UNDERTAKER W. A. Tuckner Sons	ADDRESS Hereford Md

AUG 6 1929

1—WRITE IN INK. PHYSICIANS should fill in all items. INFORMANTS should fill in all items except CAUSE OF DEATH. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

48502

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 48502

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1715 E Baltimore St. 2-4 Ward)

2-FULL NAME Benjamin Bierman

(a) RESIDENCE NO. 1715 E Baltimore St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Berman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Confectioner
(b) General nature of industry, business, or establishment in which employed (or employer) Jewish Rabbi
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Berman

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Fanny Berman
(Address) 1715 E Baltimore St

Filed ..... 192... E. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to my death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted If not at place of death? 1715 E Baltimore St

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Penton, M. D.

8.15.29 (Address) 709 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	8/16 1929
20 UNDERTAKER	ADDRESS
Jack Levi	1434 E Bulk St

AUG 16 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48503

CERTIFICATE OF DEATH

49 E 48503

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union memorial Hosp. ST., N-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Joseph Berman

(a) RESIDENCE NO. 2337 West Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ Esther Berman

6 DATE OF BIRTH (month, day, and year) Jan. ? 1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Travelling salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Dbo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mamus Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records
(Address)

15 Filed AUG 16 1929 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-15-29

17 I HEREBY CERTIFY, That I attended deceased from aug. 11, 1929, to aug. 15, 1929

that I last saw h... alive on aug. 15, 1929

and that death occurred, on the date stated above, at 9 05 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas. Post-operative

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to Liver.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/14/29

Was there an autopsy? no

What test confirmed diagnosis? Examination at Operation

(Signed) C. H. Cunningham, M. D.

8/16, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Wash. Road	8-16-1929
20 UNDERTAKER	ADDRESS
per Lewis 1439	Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 48504

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48504

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 1524 Eutaw Place 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Trauty also known as John Draude

(a) Residence No. 1524 Eutaw Place St., Ward

(Usual place of abode) 40 yrs

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.): Widowed

5a-If ~~married, widowed, or divorced~~ HUSBAND of ~~(or)~~ WIFE of: Annie Trauty

6-DATE OF BIRTH (month, day and year): Aug. 20-1859

7-AGE: 69 yrs. 11 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Andrew Draude

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-

(Informant): Maria Talbert

(Address) 1524 Eutaw Place

15-

Filed AUG 16 1929 102 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 15, 1929

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1926 to Aug 15 1929.

that I last saw h~~im~~ alive on Aug 15 1929.

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows: Of the 15th

Chronic Interstitial Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 32 N Jefferson St.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical and Microscopical Test

(Signed) Joseph K Talbert M. D.

Aug 15, 1929 (Address) 1524 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Mary's Cemetery	Aug 17, 1929
20-UNDERTAKER	ADDRESS
Galt & Lemmon	442 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

22796 E 48505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 E 48505

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pegether Thompson

(a) RESIDENCE NO. 925 - Lasenhall St - WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/27/16

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S - Car -

PARENTS

10 NAME OF FATHER Head

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lasinda Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S - Car -

14 Informant Reeds

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1929, to Aug 17, 1929, that I last saw her alive on Aug 14, 1929 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

1 acute rheumatic fever. 2. myocarditis, acute with myocardial enlargement, mitral & tricuspid insufficiency + myocardial insufficiency. (duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) terminal bronchial pneumonia (duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) W. C. Goodpasture, M. D.

8/15, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion's	Aug 17 1929
20 UNDERTAKER	ADDRESS
J. L. Broom & Son	101 W. Mont'g

HAMPTON JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48506 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 48506

CERTIFICATE OF DEATH

1—PLACE OF DEATH 932 S Eutaw St. REGISTERED NO.

CITY OF BALTIMORE: (No. 932 S Eutaw ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Johnson

(a) RESIDENCE NO. 932 S Eutaw ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Johnson

6 DATE OF BIRTH (month, day, and year): Mar 8 1875

7 AGE: Years 54 Months 5 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: domestic

(b) General nature of industry, business, or establishment in which employed (or employer): domestic

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Essex Co. Va

PARENTS

10 NAME OF FATHER: Jacob Robb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Thos Robb

(Address) 932 S Eutaw St

15 Filed AUG 15 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15/29.

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1929 to Aug 15, 1929 that I last saw h alive on Aug 14, 1929 and that death occurred, on the date stated above, at 9.50 A m.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. Hampton, M. D.

19 (Address) 701 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Aug 18 1929
20 UNDERTAKER	ADDRESS
J L Browne "Son	1018 W Mulb

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48507 46 E 48507

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 914 N Edon St. 10-14 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Robinson

(a) RESIDENCE NO. 914 N. Edon St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter J. Robinson

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: James Boyd

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Rachel Johnson

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Walter Robinson

(Address) 914 Edon St.

15 Filed ..... 19 ..... Registrar

AUG 15 1929 HARRISON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, and that said deceased came to her death (autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

15/29 (Signed) J C Ladd M. D.

(Coroner)

19 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairview Cem Harford Co Md Date of Burial Aug 17 19 29

20 UNDERTAKER: Samuel Hemsley ADDRESS 1128 Eddie

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

E 48508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

T 13E 48508

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Elling ST. 14-20 WARD)

2-FULL NAME Beverly Johnson

(a) RESIDENCE NO. 2021 Elling ST., WARD New York City

(Usual place of abode)

Length of residence in city or town where death occurred yrs mos. 6 ds. How long in U. S., if of foreign birth? yrs mos ds

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857 ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ... min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Beverly Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia Ann Dickerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Victoria Clark

(Address) 2021 Elling St

15 Filed AUG 16 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Aug 16, 1929, that I last saw h.. alive on Aug 16, 1929, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Calculus of Bladder

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Operated in New York City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) William Frey, M. D.

Aug 15, 1929 (Address) 1728 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Aug 16 1929

20 UNDERTAKER Samuel Hensley ADDRESS 1538 Bolton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-00 E 48509

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2120 Division St. 13-54 Ward)

2-FULL NAME Lorraine Lee

(a) RESIDENCE NO. 2120 Division St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fml	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) May 26-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm. Lee

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Gladys Matthews

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Gladys Lee
(Address) 2120 Division

15 Filed ..... 19.... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) Hopkins M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 16, 29
20 UNDERTAKER Samuel Weinberg	ADDRESS W. Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-006

E 48510

1-PLACE OF DEATH

City of Baltimore: (No. Good Shepherd Hosp. St., or) 14-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Butler

(a) RESIDENCE NO. 520 N. Calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet.

6 DATE OF BIRTH (month, day and year) Oct 7 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	58	10	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) Spencemus-Ottendorfer
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Cornelius Butler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna Williams

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Harriet Butler
(Address) 520 N. Calhoun

15 Filed AUG 16 1929 19 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1929

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemiplegia - Broke fell on floor. Laceration of head

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Near factory

Did an operation precede death? Yes Date Aug 3

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Hartland Hoffman, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Aug 16 29
20 UNDERTAKER	ADDRESS
Samuel J. Hensley	578 Bridge

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

48511

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 48511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1501 Lamont St., 9-18 Ward)

2-FULL NAME Jos C Corky

(a) RESIDENCE NO. 1501 Lamont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

AUG 10 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Rickets

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Ex Lues Con

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C Haas, M. D.

. 19 (Address) 436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER Undertaker Beal

ADDRESS AUG 11 1929

Per. Wm E. Woods.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

19

E 48512

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1021 Penna Ave St. 17-24 Ward)

2-FULL NAME Lottie Carter

(a) RESIDENCE NO. 1021 Penna Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no.

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: about 35 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country): "

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: N.W. Police Record
(Address)

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 6th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy & Inquest and that said deceased came to death as follows: (autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

(a) Homicide
Cerebral Hemorrhage
(duration) two hours
CONTRIBUTORY (Secondary) Fractured Skull.
(duration) Few hours

18 Where was disease contracted if not at place of death? 1021 Penna Ave.
Did an operation precede death? No (Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) H. Blick M. D.
Aug 6th 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

(Bureau of Vital Statistics)

AUG 16 1929

AUG 16 1929

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Margie Topping

E 48513

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48513

CERTIFICATE OF DEATH

1-PLACE OF DEATH Provident Hospital

City of Baltimore: (No. 660 W Fayette St., 4-25 Ward)

REGISTERED NO. 66

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margie Topping

(a) RESIDENCE NO. 660 W Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
about	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) North Carolina

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant
(Address)

15 Filed ....., 19.... HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism ?

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 660 W Fayette
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) James M Fenton M. D.
Aug 12 1929 (Address) 700 Cleveland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CEMETERY	19
20 UNDERTAKER	ADDRESS
Dulaney Hyatt	

PUBLIC HEALTH AUG 16 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48514

CERTIFICATE OF DEATH

E 48514

REGISTERED NO.

1—PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Cumberland & 6th St WARD 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Randall

(a) RESIDENCE NO. 913 Wheeler St WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eddie Randall

6 DATE OF BIRTH (month, day, and year) — 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic, 37

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer [redacted]

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER John Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Eugenia Forbes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant John Forrester.

(Address) 3022 Division St

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

AUG 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/1929

17 I HEREBY CERTIFY, That I attended deceased from 8-5-29, 19..., to 8-14-29, 19..., that I last saw h[illegible] alive on 8-14-29, 19..., and that death occurred, on the date stated above, at 6 30 p.m.

The CAUSE OF DEATH* was as follows:

Cancer uterus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia x

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of 8/10/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Aug 16 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Freeman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48515

CERTIFICATE OF DEATH.

118-001

118 E 48515

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (St.) (Ward) 58

2-FULL NAME Laurence Dorsey.

(a) RESIDENCE NO. 1028 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Bessie Dorsey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Westminister Md.

PARENTS

10 NAME OF FATHER James Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminister Md.

12 MAIDEN NAME OF MOTHER Louisa Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminister Md

14 Informant Bessie Dorsey (Address) 1028 McCulloh St.

15 Filed AUG 16 1929 19 C. HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-15-1929

17

I HEREBY CERTIFY, That I attended deceased from 8-2-, 1929. to 8-15, 1929.

that I last saw h~~im~~ live on 8-15-, 1929.

and that death occurred, on the date stated above, at 2-15 p. m.

The CAUSE OF DEATH* was as follows: Terminal Broncho-Pneumonia

Strangulated Hernia

operated (duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/2/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C. Harrison M. D.

8/15, 1929 (Address) Boonsboro

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 8/17 1929

20 UNDERTAKER Chas. S. Cooper

ADDRESS 514 N. Calhoun St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48516 — 151 — E 48516

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaiah Davis

(a) RESIDENCE NO. 1175 Bond ST., WARD Wash DC.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) May 13, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	45	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER W C H Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant City Hospitals
(Address)

15 Filed ___, 19___ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to Aug 15, 1929, that I last saw h__ alive on Aug 15, 1929, and that death occurred, on the date stated above, at 2:35 P.M.

The CAUSE OF DEATH* was as follows:

Abscess of Lung with Gangrene (duration) yrs. mos. 46 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) J. A. Harrold Jr., M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	Aug 16 1929
UNDERTAKER	ADDRESS
Frank E Campbell	Washington D.C.

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A

AUG

Spec.—2-29-28—L. F. S.—500 Blks.

Groff.

E 48517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 48517

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS 18-16

REGISTERED NO. E 48517

CITY OF BALTIMORE: (No. ..... ST. OR (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Groff.

(a) RESIDENCE NO. 204 N. Schroeder ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 17, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 6 yrs

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Groff.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adaline Esterley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed AUG 15 1929 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1929.

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1929, to August 15, 1929.

that I last saw him alive on August 15, 1929

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis with uraemia.

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? General Lab.

(Signed) Warren H. McClain, M. D.

. 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 17 19 29

20 UNDERTAKER Charles J. Kuehner ADDRESS 453 W Pratt Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 48518

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48518

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No 1105 Gorsuch Ave St. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James Thayer

(Residence in Baltimore: No. 1105 Gorsuch Ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6 DATE OF BIRTH: Dec 7 (Month) (Day), 1835 (Year)

7 AGE: 93 yrs. 8 mos. 8 ds. If LESS than 1 day, ---- hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Conn

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (State or country): England

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (State or country): England.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W M Contson

(Address) 2238 W North Ave

15.

Filed AUG 15 1929, 191 C. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug 15 (Month) (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1929, to Aug 15 1929, that I saw h[illegible] alive on Aug 15, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arteriosclerosis (Duration) yrs. mos. ds.

Contributory (SECONDARY) Only attended above name for short time his family physician during last illness (Duration) yrs. mos. ds.

(Signed), H. G. Dentist M. D.

Aug 17, 1929 (Address) 634 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Ch. S. V

DATE OF BURIAL: Aug 17, 1929

20 UNDERTAKER: W M Contson

ADDRESS: 2238 W North

Spec.—1-12-23—M&T—500 Bks.

E 48519 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 48519

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 c Shathmore Ave ST. 27-Wd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mina ~~Gordon~~ Louise Miller

(a) RESIDENCE NO. 331 c Shathmore Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infants ward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Ashby R. Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mina Louise Byers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mrs J. Byers
(Address) 331 c Shathmore Ave.

15 Filed AUG 16 1929, 19 C. HAMPSON JONES, M. D. Registrar
By RRR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Aug 14, 1929,

that I last saw h[illegible] alive on Aug 14, 1929,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diarhea & enteritis under 4 yrs 7 mo old

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. 1 hour mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Karl W. Ehrlich, M. D.

, 19 (Address) 3200 Tilbury Way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Aug 17 1929

20 UNDERTAKER W. M. Routson

ADDRESS 2238 N Mth

WARNING—RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48520

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 863 W Lombard St. 18-29 Ward)

2-FULL NAME John D McBryce

(a) RESIDENCE NO. 863 W Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6th

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
62.	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Scotland

PARENTS

10 NAME OF FATHER John McBryce

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Sarah George

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant Mrs Mary E George
(Address) 863 W Lombard St.

15 ... 19 ...

AUG 16 1929

C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypertension Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of

Was there a autopsy? No

What test confirmed diagnosis? History

(Signed) G C Glader, M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 12 1929
20 UNDERTAKER	ADDRESS
John J Cowne & Son	901 Hollins

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48521

CERTIFICATE OF DEATH

88 E 48521

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 14-30 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Medora Boone

(a) RESIDENCE NO. 1730 Druid Hill Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Boone

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Tibotha Rollins

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed AUG 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929 to August 13, 1929

that I last saw her alive on August 13, 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab Exam.

(Signed) Marvin W. McClain, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cemetery	1929
20 UNDERTAKER George T. A. Gibbs	ADDRESS 735 Druid Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 48522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92E 48522

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital (Ward) 20-20

2-FULL NAME James A. Lockard

(a) RESIDENCE NO. 75 - Russell St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 27- 1864

7 AGE — Years: 65 — Months: 2 — Days: 18 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto Co. Md

PARENTS

10 NAME OF FATHER: Ranger D. Lockard

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Maggie Carr

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Mrs James W. Lockard

(Address): 75 Russell St

15 Filed: C. HAMPSON JONES, M. D. Registrar

AUG 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14 29 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden

(Duration) yrs. mos. ds.

Aug 16 (Signed) W. F. Luhy (Coroner) M. D.

, 19 29 (Address) 1659 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs... ...mos... ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sandy Mount Carroll Co Date of Burial: Aug 17 19 29

20 UNDERTAKER: Geo L Schwab ADDRESS: 1101 Fed

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48523

CERTIFICATE OF DEATH

45V E 48523

1—PLACE OF DEATH Union Memorial Hospital — REGISTERED NO. 12-49

CITY OF BALTIMORE: (No. 23 rd to Calvert ST. KATHARINE A. DOWNES WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Joseph L. Downes (Catherine)

(a) RESIDENCE NO. 2201 ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph L Downs.

6 DATE OF BIRTH (month, day, and year) Feb 2, 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER John H Anderson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah E. Kindig

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Richard Hyde (Son)
(Address)

15 Filed AUG 16 1929 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Aug 15, 1929, that I last saw h alive on ....., 19 ..., and that death occurred, on the date stated above, at 8.55 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the intestines.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 8, 1928

Was there an autopsy? Yes

What test confirmed diagnosis? Respiration and pulse ceased.

(Signed) H Cunningham M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	8/17 1929
UNDERTAKER Henry U Means & Son	ADDRESS 805 N. Calvert

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Form tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48524

CERTIFICATE OF DEATH.

59 E 48524

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Gt B Marine Hospital 21-29 Ward)

2-FULL NAME Louis U. Drain

(a) RESIDENCE NO. 809-Woodward St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-16-89

7 AGE — Years: 40 — Months: — Days: 22 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Disabled - USA

(b) General nature of industry, business, or establishment in which employed (or employer): Soldier Veteran

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Talbot Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) " "

14 Informant Nat'l H. & A. Co.

(Address)

15 Filed _____ 19____ C. HAMPSON JONES, M. D. Registrar

AUG 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to _____ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tumor of Hypophysis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Increased Intra Cranial pressure

(duration) 2 yrs. ____ mos. ____ ds.

(Signed) H. Hampson Jones M. D.

8/16, 1929 (Address) 2602 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem — Date of Burial 8/17 1929

20 UNDERTAKER: Robert Brooks & Son — ADDRESS Catho... Holl...

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48525

CERTIFICATE OF DEATH

44 E 48525

1—PLACE OF DEATH

REGISTERED NO. 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4406 Wrmwood Ave ST. WARD)

2—FULL NAME Mary E. Lauber

(a) RESIDENCE NO. 4406 Wrmwood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced (or) WIFE of Frederic Lauber

6 DATE OF BIRTH (month, day, and year) Jan ? 1863

7 AGE: Years 66 Months 7 Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Nicholas Barkhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Liz Weigand

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: R. Brooks

(Address) 17 Calhoun St

15 Filed AUG 18 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15-29

17 I HEREBY CERTIFY, That I attended deceased from July 20th, 1929, to Aug 14th, 1929, that I last saw h[illegible] alive on Aug 15th, 1929 and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Gastric)

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Robert S. Kirk, M. D.

8/16, 1929 (Address) 3126 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 8/17 1929

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun [illegible]

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

UG 18 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 48526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 48526

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 Melville Ave ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George C. Spies

(a) RESIDENCE NO. 619 Melville Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 5 mos. 30 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia A. Mehrling

6 DATE OF BIRTH (month, day, and year) Feb-16-1861

7 AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	68	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman Meats

(b) General nature of industry, business, or establishment in which employed (or employer) Wagner Bros

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Geo. C. Spies

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Susanna Hitzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Calvin E. Mehrling

(Address) 619 Melville Ave

15 Filed AUG 16 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1929, to Aug 14, 1929, that I last saw him alive on Aug 14, 1929 and that death occurred, on the date stated above, at 10.30A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no -

What test confirmed diagnosis? Clinical -

(Signed) John S. Fenby, M. D.

8/15, 1929 (Address) 3522 greenmount ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Aug 17 1929

UNDERTAKER: P. B. Wippert, ADDRESS: 1850 W. Baltimore ST.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48527

CERTIFICATE OF DEATH

74-001

E 48527

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sister Annie Killion

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): March 22 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	4	26 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious duties

(b) General nature of industry, business, or establishment in which employed (or employer): Home 16

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Unknown Delaware

PARENTS

10 NAME OF FATHER: Timothy Killion

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Ireland

12 MAIDEN NAME OF MOTHER: Anna Kilroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Ireland

14 Informant: Mt Hope Retreat
(Address): Mt Hope Retreat

15 Filed ... 19 ... By ... Registrar

C. HAMPSON JONES, M.

UG 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 16-1929

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1925, to Aug 16, 1929,

that I last saw h[illegible] alive on Aug 15, 1929

and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(2nd attack)

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary): Paralysis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Fell M. D.

19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Hope Cemetery	August 17th 1929
20 UNDERTAKER	**ADDRESS**
Stewart & Mowen Company	108 W. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Corine Hurst

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 cc 106 E 48528 — 16-002 E 48528

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Corinne Horst

(a) RESIDENCE NO. 10 N. Dallas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	Colored	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Benny Horst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 17 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15 29

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1929, to August 15, 1929, that I last saw h[illegible] alive on August 15, 1929 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Dysentery.

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Campbell Gradwohl, M. D.

Aug. 16, 1929 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leisure Cem.	Aug. 18 1929
20 UNDERTAKER Mrs J. G. Locks	ADDRESS 1302 Jeffers.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2-8-14-3 E 48529 — CERTIFICATE OF DEATH — X 101-001 E 48529

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6-9 WARD)

2—FULL NAME John McLaren

(a) RESIDENCE NO. 1747 Mulliken ST., WARD Georgia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER John McLaren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Louisa Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 17 1929 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 15/29

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1929, to August 15, 1929, that I last saw h.. alive on August 15, 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia, left lung.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical examination.

(Signed) H. C. Goodwin, M. D.

8/15, 1929 (Address) J. H. Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	Aug 17 1929
20 UNDERTAKER Thos J. S. Socks	ADDRESS 1302 Jeffer

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48530

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48530

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 118-60

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland General Hospital 29-54 WARD)

2—FULL NAME Margaret Staines

(a) RESIDENCE NO. 6086 Falls Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Caucasian	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Staines

6 DATE OF BIRTH (month, day, and year) July 6, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Priscilla Russel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County, Md

14 Informant Hospital Records
(Address)

15 FILED AUG 17 1929, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-29

17

I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1929, to Aug 16, 1929, that I last saw h.. alive on 8-16, 1929 and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Postoperative Ventral hernia.

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction Paralytic Ileus (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8-12-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. D. Dempsey M.D.

(Address) 6086 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sherwood Church Cemetery	Aug 19 1929
UNDERTAKER A. S. Marshall	ADDRESS 3539 Falls Road

AUG 17 1929

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48531

HEALTH DEPARTMENT—CITY OF BALTIMORE

135

E 48531

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Wyszecki

(a) RESIDENCE NO. 516 S. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp. Record.

(Address)

15 Filed AUG 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15/29

17 I HEREBY CERTIFY, That I attended deceased from 8/13, 19 29, to 8/15, 19 29, that I last saw him alive on 8/13, 19 29 and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy Prostate

Urinary retention

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of lungs

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 8/6/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Weinstein, M. D.

8/16, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Aug 19	1929
20 UNDERTAKER	ADDRESS
F. W. Ozazewski	1930 Eastern Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 48532 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 4853

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 Calhoun St., 16-22 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Doris Agnes

(a) Residence No. 1105 Calhoun St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 0

6-DATE OF BIRTH (month, day and year) Oct 24, 25

7-AGE. yrs. 9 mos. 22 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. 0

(b) General nature of industry, business, or establishment in which employed (or employer). 0

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. William Agnes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Annie Brent

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14-

(Informant). Mrs Agnes

(Address) 1105 Calhoun St

15-

Filed AUG 17 1929 C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 16, 29

17- I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 16, 1929.

That I last saw her alive on Aug 15, 1929

and that death occurred, on the date stated above, at 7 A. m.

THE CAUSE OF DEATH* was as follows: Acute Gastritis and Enteritis

(Duration) day mos. 3 ds.

CONTRIBUTORY (Secondary) 0

(Duration) 0 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? 1105 Calhoun St

Did an operation precede death? No Date of 0

Was there an autopsy? No

What test confirmed diagnosis? Not any

(Signed) John C Stewart M. D.

Aug 16 1929 (Address) 704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. Aug 17 1929

20-UNDERTAKER. Samuel W. Edmondson & Son

ADDRESS 1420 Harlem

WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48533

CERTIFICATE OF DEATH

38 E 48533

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 207 Aisquith ST. 5-8 WARD)

2—FULL NAME Arianna Kirby

(a) RESIDENCE NO. 207 Aisquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wilson Kirby

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	>	>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Kinrod Downs

(Address) 517 N. Carey St.

15 Filed 1 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15/29

17 I HEREBY CERTIFY, That I attended deceased from 8/5/29, 19..., to 8/15/29, 19...

that I last saw h... alive on 8/14/29, 19...

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Pneumonia (duration) Acute yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) O. Hampson Jones, M. D.

8/16/29 19 (Address) 708 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Ch	Aug 17 1929
20 UNDERTAKER	ADDRESS
D. E. Brandt & Son	1011 W. Mulberry

. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificates.

UG

Spec.—1-12-23—M&T—500 Blks.

E 48534 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 48534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1638 Gilmor ST. 15-21 WARD)

2-FULL NAME Charlotte Wilson

(a) RESIDENCE NO. 1638 Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Henry Wilson

6 DATE OF BIRTH (month, day, and year): 1/10/6

7 AGE: Years 23; Months; Days; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Mary J. Griffin 1638 Gilmor St.

15 Filed ..... 19 ..... Registrar. C. HAMPSON JONES, M. D.

G 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/16/29

17 I HEREBY CERTIFY, That I attended deceased from 2/20, 1929, to 8/16, 1929, that I last saw her alive on 8/15, 1929, and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Phthysis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Curtis, M. D.

(Address) 1730 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Aug 19 1929

20 UNDERTAKER: Virginia A. Brooks — ADDRESS: 1463 W Carey St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated—EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

228 E 48535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48535

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Meyer

(a) RESIDENCE NO. 2505-Garrison ST., Bert WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/5/92

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md—

PARENTS

10 NAME OF FATHER Wm Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bay Hyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austrian

14 Informant Friends-

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Aug 16, 1929, that I last saw him alive on Aug 16, 1929 and that death occurred, on the date stated above, at 4 5. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gemual Laboratory

(Signed) C. Hampson Jones M. D.

Aug 14 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Herring Run	8-16-1929
20 UNDERTAKER	ADDRESS
Jack Lewis, 1439	Baltimore St

mation should be carefully supplied. AGE should be s
OF DEATH in plain terms, so that it may be properly
important. See instructions on back of certificates.

AUG 17 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 48536

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48536

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3126 Abell Ave. ST. 12-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie Louise Winne

(a) RESIDENCE NO. 3126 Abell Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene H. Winne

6 DATE OF BIRTH (month, day, and year) July 14, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER Mr. Sprague

11 BIRTHPLACE OF FATHER (city or town) (State or country) United States

12 MAIDEN NAME OF MOTHER Harriett M. (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) United States

14 Informant Mr. J. Homer Winne

(Address) 3126 Abell Avenue

15 Filed AUG 17 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 16, 1929, that I last saw her alive on Aug 15, 19, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH was as follows:

Bright's Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Aug. 17, 1929 (Address) 1834 E. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albany, New York

DATE OF BURIAL Aug. 18, 1929

20 UNDERTAKER [illegible]

ADDRESS 1003 West Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48537

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 74 E 48537

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1019 Riverside Ave. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A. Betsworth

(a) RESIDENCE NO. 1019 Riverside Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 2 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lenora Betsworth

6 DATE OF BIRTH (month, day, and year) May 23 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	79	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Walter E. Hart

(Address) 1019 Riverside Ave.

15 Filed AUG 17 1929 C. HAMPSON JONES, Registrar M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 12/29, 19 . to Aug 17/29, 19 . that I last saw him alive on Aug 17/29, 19 and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis, (Hemiplegia) Cerebral

(duration) Hyp Blood Pressure yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm B Holly M. D.

Aug 17/29 (Address) 1703 Eight

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Aug 19 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAREFUL OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48538

CERTIFICATE OF DEATH

129

E 48538

1—PLACE OF DEATH

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. 2222 N. Charles St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose A. Sullivan

(a) RESIDENCE NO. 2222 N. Charles St ST., WARD

(Usual place of abode) 77

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late William H. Sullivan

6 DATE OF BIRTH (month, day, and year) July 27, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work AT HOME

(b) General nature of industry, bosiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Nicholas Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph M. Sullivan

(Address) 2222 N. Charles St.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

AUG 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-1929

17

I HEREBY CERTIFY, That I attended deceased from for about 1 Prat. Hospital, 19..., to Aug 16, 1929.

that I last saw her alive on Aug 11-8-16, 1929

and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease - Chronic Nephritis - Arteriosclerosis - High Blood Pressure.

several yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) age —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A R Gorsuch, M. D.

, 19 (Address) 1121 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	8/19/29

20 UNDERTAKER Sam'l Witzke, 53 W Lombard St ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

E 48539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 48539

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alex. McNeill

(a) RESIDENCE NO. 1100 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Isaac McNeill

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Record

(Address)

15 Filed AUG 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/29

17 I HEREBY CERTIFY, That I attended deceased from 6/18, 1929, to 8/14, 1929, that I last saw h[illegible] alive on 8/14, 1929 and that death occurred, on the date stated above, at 6 45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate
Metastasis to spinal bone

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Pumphrey, M. D.

8/14, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8/19 1929
20 UNDERTAKER	ADDRESS
Eden Bryan	1131 Orleans St

Information should be carefully supplied. All items should be stated. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

(Divers Hick Jones)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48540

CERTIFICATE OF DEATH

44 E 48540

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4428 Edmondwood Ave ST.) 27-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Divers Hick-Jones

(a) RESIDENCE NO. 4428 WYFENWOOD AVE. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs D. H Jones

6 DATE OF BIRTH (month, day, and year) Feb 17 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	69	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Lemberg Fish Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Theo - Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Hammil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wife

(Address)

15 Filed AUG 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 29

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1929, to Aug 17, 1929, that I last saw h.. alive on Aug 16, 1929 and that death occurred, on the date stated above, at 7 20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung - fracture

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 9 29

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Pathological

(Signed) H Shelton, M. D.

, 19 (Address) 4305 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Lawn Md	Aug 19 1929
20 UNDERTAKER William Cook	ADDRESS 1417 Sharp

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 48541

REGISTERED NO.

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard + Green ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence albert Cox

(a) RESIDENCE NO. 2836 Riggs Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Murrial C Cox

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Emma H Myers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Murrial C Cox
(Address) 2836 Riggs Ave

15 Filed AUG 17 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1929 to Aug 15, 1929

that I last saw h. \ Walive on Aug 15, 1929

and that death occurred, on the date stated above, at 5.50 P.m.

The CAUSE OF DEATH* was as follows:

Malnutrition
gastro-enteritis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Walter B Johnson, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	8/17 1929
20 UNDERTAKER D. H. Cook	ADDRESS 1217 St Paul St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48542

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48542

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2017 Oak ST. 12-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Allen

(a) RESIDENCE NO. 2017 Oak ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school - boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anderson,
(State or country) S. C.

PARENTS

10 NAME OF FATHER James Allen

11 BIRTHPLACE OF FATHER (city or town) Anderson
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Mattie Ellis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. C.

14 Informant Mattie Allen
(Address) 2017 Oak St

15 Filed AUG 17 1923, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1929

17

I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to Aug 14, 1929.

that I last saw him alive on Aug 13, 1929

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows: Pulmonary T.B.

(duration) yrs. 4 mos 14 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin Test

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Aug. 16 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 3221 Schroeder St

WHERE PLURAL, WITH CONFIRMATION, ... mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48543

CERTIFICATE OF DEATH.

74-801

E 48543

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3535 Bentalou ST. 91-64 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Tamm

(a) RESIDENCE NO. 3535 S. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Tamm

6 DATE OF BIRTH (month, day, and year): Nov. 20-1865

7 AGE: Years 64 Months 4 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: John Tamm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Anna Inegar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Mrs. Maria Tamm (Address) 3536 Bentalou St.

15 Filed AUG 17 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1929, to Aug 15, 1929, that I last saw him alive on , 19 , and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Aug 16, 1929 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnstown Pa

DATE OF BURIAL: Aug 17 1929

20 UNDERTAKER: George L. Schwab

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

22E 078
22E 48544

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 84 E 48544

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2—FULL NAME Eleanor Preston

(a) RESIDENCE NO. Aberdeen ST., Md— WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/8/21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md—

PARENTS

10 NAME OF FATHER Arthur Preston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md—

12 MAIDEN NAME OF MOTHER Ella Greet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md—

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 17 1929 19 H. AMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-17-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 17, 1929, that I last saw her alive on Aug 17, 1929 and that death occurred, on the date stated above, at 11:5 a m.

The CAUSE OF DEATH* was as follows:

Brain tumor, brain stem, glioma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Aug 17, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation + autopsy

(Signed) Clarence E Gardner Jr, M. D.

8/17, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md

DATE OF BURIAL: 8/17 1929

20 UNDERTAKER: W. L. Tuckers & Sons

ADDRESS: Pa.

mation should be carefully supplied. AGE should be stated
OF DEATH in plain terms, so that it may be properly clas
important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

1.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 48545

E 48545 CERTIFICATE OF DEATH

REGISTERED NO. C

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE (No. 4221 Pimlico Road St. 15-56 WARD)

2 FULL NAME Leonard Sutterman

(Residence in Baltimore: No. 4221 Pimlico Road St.: Yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April (Month) 28 (Day), 1927 (Year)

7 AGE: 2 yrs. 3 mos. 20 ds. (19) If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: David Sutterman

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Frisis Fromt

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Lewis

(Address) 1739 E Balto. St.

Filed AUG 18 1928 H. HARRISON JONES, M. D. REGISTRAR

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 17 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May-28-1929 to Aug-17-1929 that I saw h[illegible] alive on Aug-17-1929 and that death occurred, on the date stated above, at 12 30 P. m.
The CAUSE OF DEATH* was as follows:

Lympho-Sarcoma
(Prob. Multiple Myelomata)

(Duration) yrs. 4 mos. ds

Contributory (SECONDARY) Biopsy did not give definit information

(Duration) yrs. mos. ds.

(Signed) Herman Seidel M. D.

Aug-17-1929 (Address) 2404 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Herman Rosedale — DATE OF BURIAL: 8-18-1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1739 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

E 48546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48546

1—PLACE OF DEATH Hebrew Home for Incurables — REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Levy

(a) RESIDENCE NO. Hebrew Incurables Hms WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Levy

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE — Years: 60 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0-37

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Lewis

(Address): 1439 E Balto St

15 Filed AUG 13 1929 — I. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug-17-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug-2-, 1929, to Aug-17-, 1929, that I last saw her alive on Aug-17-, 1929, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Myo-Cardial Insufficiency

about 6 months
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia
(duration) yrs. mos. Days

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Bendel, M. D.

8-17-1929 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rawng Run — DATE OF BURIAL: 8-18-1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

Information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48547

CERTIFICATE OF DEATH.

E 48547

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Northwest & Patterson (St.) 45-6 (Ward)

2-FULL NAME Simon Epstein

(a) RESIDENCE NO. 1733 Moreland ST., (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Epstein

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1429 E Balto

Filed AUG 18 1929 S. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-18- 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-22 , 1929 , to 8-18 , 1929 .

that I last saw him alive on 8-18 , 1929 ,

and that death occurred, on the date stated above, at 12:10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Benign Prostatic hypertrophy

uncertain (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-25-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) J. H. Cohn Jr. M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Lebanon Cem

DATE OF BURIAL 8-18-1929

20 UNDERTAKER Jack Lewis, 1429 E Balto

ADDRESS

21

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48548 — 90E 48548

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Ruxton Ave., St. 15-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Israelson

(a) RESIDENCE NO. 1906 Ruxton Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Israelson

6 DATE OF BIRTH (month, day, and year): December

7 AGE: Years 66 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Russia~~ Retired

(b) General nature of Industry, business, or establishment in which employed (or employer): no

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Israelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rettie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: S. Lewis

(Address): 1429 E. Baltimore St.

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

AUG 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 17th 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 12th 1929 to Aug 17th 1929

that I last saw h[illegible] alive on Aug 17th 1929

and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary): Diarrhea

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel Hamburger M. D.

8/17/29 (Address) 3735 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Southern Ave.

DATE OF BURIAL: 8-18-29

20 UNDERTAKER: Jack Lewis

ADDRESS: 1429 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48549

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1020 N. Eutaw St 1-21 Ward)

2-FULL NAME Edna Johnson

(a) RESIDENCE NO. 1020 N. Eutaw St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col'd

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas. M. Johnson

6 DATE OF BIRTH (month, day, and year): Mar 1886

7 AGE — Years: 43 — Months: 5 — Days: — — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Richmond
(State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Va.
(State or country)

12 MAIDEN NAME OF MOTHER: Jessie James

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Jas. M. Johnson
(Address) 1020 N. Eutaw St

15 Filed ..... 19..... HARRISON JONES, M. D. Registrar

AUG 19 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rheumatism
Acute Endocarditis
(duration) ..... yrs. 1 week.
CONTRIBUTORY (Secondary) Rheumatism
(duration) ..... yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? 1020 N. Eutaw

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Falk, M. D.

Aug 19 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: Aug 19 29

20 UNDERTAKER: Samuel Brumley — ADDRESS: 1123 Pa

Spec.—2-29-28—L. F. S.—500 Bks.

E 48550 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

7-09

REGISTERED NO. E 48550

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3454 Seneca ST., 13 WARD

2—FULL NAME Jacob M. Stilhelm

(a) RESIDENCE NO. 3454 Seneca ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ruth L. Stilhelm

6 DATE OF BIRTH (month, day, and year): March 9-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mail Carrier 88

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Retired 8 years

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: John Stilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Ruth L. Stilhelm

(Address) 3648 Falls Road

15 Filed ..... 19 ..... HARRISON JONES, M. D. Registrar

AUG 18 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 16-1929

17 I HEREBY CERTIFY, That I attended deceased from July 20. 1929. to Aug 15. 1929

that I last saw him alive on Aug 15. 1929

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Chronic Hypertension

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Bones, M. D.

8-17 1929 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel (Balto. Co.)	Aug. 19 1929

20 UNDERTAKER: Horace F. Burgee ADDRESS 3631 Falls Road

IMPORTANT—Fill out this certificate properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-010

E 48551

CERTIFICATE OF DEATH

E 48551
REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank A. Schmidt

(a) RESIDENCE NO. 1613 Frederick Ave St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mns. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Child

5a If married, widnwed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Mar 7-1920

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	9	5	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) ———
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Schmidt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Jacobs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Frank Schmidt
(Address) 1613 Frederick Ave

15 Filed AUG 18 1929 19 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Comp. Com. Fract. Skull
boy fell from bicycle under rear wheel of truck crushing his skull
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Distraction
by Trauma
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Frederick Ave
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) P. J. Frame, M. D.
8/18 19 29 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Aug 19 1929
20 UNDERTAKER Charles H Kehner	ADDRESS 1531 Hollins

Spec.—2-29-28—L. F. S.—500 Blks.

E 48552

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48552

CERTIFICATE OF DEATH

1—PLACE OF DEATH Aged Womens Home — REGISTERED NO. 14-27

CITY OF BALTIMORE: (No. 1400 W Lexington ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Augusith

(a) RESIDENCE NO. 1400 W Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 18-1847

7 AGE: Years 82 | Months 3 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Miss Margaret Baker

(Address) 1400 W Lexington St

15 Filed Aug 18 1929, 19 C. HAMPSON JONES Registrar

Per EEC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17-1929

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to Aug. 17, 1929, that I last saw h N alive on Aug. 5, 1929 and that death occurred, on the date stated above, at 9:50 p. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertrophic Arthritis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin D. Jarrett M. D.

, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harpers Ferry W Va

DATE OF BURIAL: Aug 19 1929

20 UNDERTAKER: L. D. George J Smith

ADDRESS: 1532 Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48553

CERTIFICATE OF DEATH

49 ✓ E 48553

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Md Gen Hosp St. 14-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Mumford (Thos. Howard Emberly)

(a) RESIDENCE NO. 1700 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 1 mos. — ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married (Mary R. Dolly)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Howard Mumford

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1874

7 AGE 54 Years 8 (3) Months 16 Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co Md

PARENTS

10 NAME OF FATHER Thomas A Embert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Hills

12 MAIDEN NAME OF MOTHER Not obtainable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Hospt Records

(Address)

15 AUG 18 1929 HARRISON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16/29

17 I HEREBY CERTIFY, That I attended deceased from 8/11/29 19..., to 8/16/29 19..., that I last saw him alive on 8/16/29 and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of head

Contributory 2nd Ca. ?, Liver

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 8/19 1929

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 806 N. Calvert

Information should be carefully supplied. Avoid abbreviations. Write plainly with ink. Be sure that OCCUPATION is very properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

48554 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48554

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1089 E. Randall St. Ward)

2-FULL NAME Rosie A. Buckey

(a) RESIDENCE NO. 108 E Randall St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 61 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER C. Gramling

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Bopp

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Mrs A. Schaffer

(Address) 1108 Randall

15 Filed AUG 18 1929 19 H. McSherry Jones M.D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia. Edema.

(duration) yrs. mos. ds.

(Signed) M. D.

Aug 18, 19 29 (Coroner)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial 8/19 1929

20 UNDERTAKER: J. Frew McCully ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48555

CERTIFICATE OF DEATH.

57 E 48555

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 N Lafayette Ave ST. 16-W WARD)

2-FULL NAME Albert A. Torney

(a) RESIDENCE NO. 2809 N Lafayette Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Barbara Torney

6 DATE OF BIRTH (month, day, and year) Sept 21 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lieut Fire Dept

(b) General nature of industry, business, or establishment in which employed (or employer) 932

(c) Name of employer Balto Fire Dept

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Albert Torney

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Anna Wright

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Eles. A. Torney (Address) 1106 Washington Blvd

15 Filed AUG 18 1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Jany 8, 1929, to Aug 17, 1929, that I last saw him alive on Aug 16, 1929, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 7 mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

8/17, 1929 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 19 1929

20 UNDERTAKER George L. Schmidt & Son ADDRESS Eutaw & Lanvale Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48556 HEALTH DEPARTMENT—CITY OF BALTIMORE. E 48556

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 Hollins ST. 20-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie E. Knighton

(a) RESIDENCE NO. 2035 Hollins ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 29-1855

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	5	18	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary E. Knighton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. P. Kauffman

(Address) 2035 Hollins St

15 Filed AUG 18 1929, 19 C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17. 19 29

17 I HEREBY CERTIFY, That I attended deceased from 5/1- , 19 28. to 8/17- , 19 29.

that I last saw h alive on 8/16- , 19 29

and that death occurred, on the date stated above, at 4³⁰ A m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis Hypertension

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure

(Signed) Chas A Cahn, M. D.

8.27 (Address) 2105 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 19 1929
20 UNDERTAKER	ADDRESS
George L. Schmat	3101 Eutaw Pl

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48557

CERTIFICATE OF DEATH

57

E 48557

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST. 17-24 WARD)

2—FULL NAME Laura Scott

(a) RESIDENCE NO. 517 W Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W Scott

6 DATE OF BIRTH (month, day, and year): Sept. 1860

7 AGE — Years: 68 — Months: 11 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: John W Scott

(Address) New York — N.Y.

15 Filed AUG 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1929, to August 15, 1929,

that I last saw her alive on August 15, 1929

and that death occurred, on the date stated above, at 2.05 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) 8 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death?: No Date of

Was there an autopsy?: No

What test confirmed diagnosis?

(Signed) Samuel T. Hatem, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn, Md. Mg

DATE OF BURIAL: 8/18/1929

20 UNDERTAKER: Mrs. Geo. H. Holla

ADDRESS 1163 Lund St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48558

24 E 48558

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital WARD) 14-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alpheus Elmer Haynie

(a) RESIDENCE NO. 1411 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Multigraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General Baking Co

9 BIRTHPLACE (city or town) (State or country) Fairport Va

PARENTS

10 NAME OF FATHER Alpheus Haynie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fairport Va

12 MAIDEN NAME OF MOTHER Maud Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Alpheus J. Haynie

(Address) 1411 W. Lexington St

15 Filed C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929 to Aug 16, 1929 that I last saw him alive on Aug 16 1929 and that death occurred, on the date stated above, at 8.05 p m.

The CAUSE OF DEATH* was as follows:

Meningitis (Meningococcic)

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) None —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1411 W. Lexington

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Spinal puncture + clinical findings

(Signed) Addison Croft Irby M. D.

8-17 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sandy Cack	Aug 19, 1929

20 UNDERTAKER ADDRESS

F. B. Nisbet 1850 W Balto. 17

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48559 66 E 48559

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 114 Bealton ST. 8-29 WARD)

2—FULL NAME Mrs Rebecca Needy

(a) RESIDENCE NO. 114 Bealton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~ (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Needy Hutton

6 DATE OF BIRTH (month, day, and year) March 27-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hunter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Hylton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pontflow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Needy Hutton

(Address) 114 Bealton St

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-15-29

17 I HEREBY CERTIFY, That I attended deceased from August 12, 1929, to 8-15-, 1929

that I last saw h alive on 8-15- 1929

and that death occurred, on the date stated above, at 4 O 5 M.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Dean, M. D.

, 19 (Address) 227 North Bl'd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 16 1929

20 UNDERTAKER John J Fields — ADDRESS 1200 W Lombard

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 19 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48560

CERTIFICATE OF DEATH

90 E 48560

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2027 Eastern Ave ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Oszakiewski

(a) RESIDENCE NO. 2027 Eastern Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Oszakiewski

6 DATE OF BIRTH (month, day, and year) Jan 19 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Oszakiewski (Address) 2027 Eastern Ave

15 Filed AUG 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1929

17 I HEREBY CERTIFY, That I attended deceased from July 7 19 28 to Aug 16 19 29

that I last saw him alive on Aug 16 19 29

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Chronic arteriosclerosis & Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Karl Krugler, M. D.

8/17, 19 29 (Address) 2027 E. Baltimore

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Aug 20 1929
20 UNDERTAKER	ADDRESS
M. W. E. D. Spulane	37 Conant

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48561

CERTIFICATE OF DEATH

57 E 48561

1—PLACE OF DEATH University Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ____ ST., 3-4 WARD)

2—FULL NAME Marie Durando

(a) RESIDENCE NO. 1504 Toms St ST., ____ WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred Durando.

6 DATE OF BIRTH (month, day, and year): Oct. 27 1877

7 AGE: Years 51 | Months 9 | Days 19. | If LESS than 1 day, hrs. or min. ____

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: House Work.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS:
10 NAME OF FATHER: Not known
11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy
12 MAIDEN NAME OF MOTHER: Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Fred Durando
(Address) 1504 Toms St

15 Filed AUG 16 1929 19 C. HERBERT JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15th, 1929. to August 16, 1929.
that I last saw h alive on August 16, 1929
and that death occurred, on the date stated above, at 2.32 A m.

The CAUSE OF DEATH* was as follows:
Diabetic Coma
(Diabetes Mellitus) 5 Years
(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. Tendy, M. D.

8 16, 1929 (Address) Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: Aug 16 1929.

20 UNDERTAKER: Kendall - J Lippel — ADDRESS: 300 E Eden

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48562

CERTIFICATE OF DEATH

31

E 48562

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2004 Ashland Av ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Holoda

(a) RESIDENCE NO. 2004 Ashland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Holoda

6 DATE OF BIRTH (month, day, and year) Oct 10 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	51	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Holoda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mrs Holoda Wife

(Address) 2004 Ashland Av

15 Filed AUG 18 1929, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17th 29

17 I HEREBY CERTIFY, That I attended deceased from 8-1-29, 19 , to 8-17-29, 19 ,

that I last saw him alive on 8-17-29, 19

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows: Phthisis Florida

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis? Evidence

(Signed) M. D.

Aug. 19 29 (Address) 2416 Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Aug 19 1929
20 UNDERTAKER	ADDRESS
Max Bracken 1916	Ashland

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

AUG 18 1929

Spec.—1-12-23—M&T—500 Blks.

E48563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 **E 48563**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Agnes Hosp. ST. 13-52 WARD)

2-FULL NAME Mrs. Alice Kemp

(a) RESIDENCE NO. 3508 Elm Ave. City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
f.	W.	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of William A Kemp

6 DATE OF BIRTH (month, day, and year) Sept 13-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70	70	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss M. Kemp

(Address) 3508 Elm ave.

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

G 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-18 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-14, 1929, to 8-18, 1929, that I last saw h[illegible] alive on 8/18, 1929 and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Complete Obstruction

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 15-29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Fernando C. Rucker M. D.

, 19 (Address) 704 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 20, 19 29
20 UNDERTAKER	ADDRESS
A S Marshall	3534 Fallsway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48564

CERTIFICATE OF DEATH

E 48564

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

2—FULL NAME Michael R. Bentz

(a) RESIDENCE NO. Finksburg, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White Caucasian	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Michael R. Bentz

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York, Penn.

PARENTS

10 NAME OF FATHER Michael H. Bentz

11 BIRTHPLACE OF FATHER (city or town) York (State or country) Penn.

12 MAIDEN NAME OF MOTHER Louise Reiker

13 BIRTHPLACE OF MOTHER (city or town) York (State or country) Penn.

14 Informant Hospital Records (Address)

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1929, to Aug. 19, 1929, that I last saw him alive on Aug. 19, 1929 and that death occurred, on the date stated above, at 6:20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rt. Lung

(duration) yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Cancerous of Rt. Inguinal Lg. (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug. 16, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Finksburg, Md	Aug 21 1929
20 UNDERTAKER	ADDRESS
J. A. Shenk & Son	Westminster Md
F. Francis Reed	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C 191929

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48565 — 90 ✓ E 48565

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4 Merrymount Rd (ST.) Roland Park (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August W. Wehr

(a) RESIDENCE NO. 5 Merrymount Rd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Genevieve Pennington Wehr

6 DATE OF BIRTH (month, day, and year) Nov 22, 1898

7 AGE	Years	Months 8	Days	If LESS than 1 day, ... hrs. or ... min.
	30	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER William F. Wehr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bertha Lewis

13 BIRTHPLACE OF MOTHER (city or town) Madison (State or country) Maryland

14 Informant Frederick L. Wehr (Address) 3829 Beechawn

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

AUG 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug. 17, 1929, that I last saw h alive on Aug. 16, 1929. and that death occurred, on the date stated above, at about 6-30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus.

... (duration) yrs. ... mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis Fr. Emphysema (duration) 3 yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) M. Tobin Porter, M. D.

8/18, 1929 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Aug 19 1929

20 UNDERTAKER Henry F. Jenkins Sons ADDRESS McCulloh & Orchard Sts.

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-29—M&T—1500 Bks.

E 48566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 48566

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mrs Garlis Sam.

CITY OF BALTIMORE. (No.) Belle Ave Govans. St. 12-50 (WARD)

2-FULL NAME Virginia A Reid

(a) RESIDENCE No. 203 E. 33rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Thomas A. Reid

6 DATE OF BIRTH (month, day, and year) Oct 15 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fincastle Va

PARENTS

10 NAME OF FATHER Benjamin Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Naomi Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant E. Emmett Reid

(Address) 203 E 33rd St.

15 Filed AUG 19 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-17 1929

17 I HEREBY CERTIFY, That I attended deceased from July-1 1929 to aug-17 1929, that I last saw h alive on aug 16 1929, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 2 yrs mos ds.

CONTRIBUTORY (Secondary) Gen. Carcinomatosis

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Hours, M. D.

8-18 1929 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Aug 19 1929

20 UNDERTAKER John O Mitchell Sons ADDRESS 1400 Eutaw Place

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48567

CERTIFICATE OF DEATH

129 E 48567.

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 E. Lanvale ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Valletta M. Wilson

(a) RESIDENCE NO. 1419 E. Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Ritchie Wilson

6 DATE OF BIRTH (month, day, and year) Sept. 19-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. F. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John Ritchie Wilson
(Address) 1419 E. Lanvale St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

UG 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 16, 1929, that I last saw h.. alive on 11 11, 1929 and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease

(duration) yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. Carr M. D.

8/17 1929 (Address) 3907 Fairmount Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Aug. 19 1929

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH

E 48568

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

City of BALTIMORE: (No. 8-12 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. Lane

(a) RESIDENCE NO. 2732 E. Chase St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Mrs. Jos. Lane

6 DATE OF BIRTH (month, day, and year) 12/7/1874

7 AGE	Years	Months	Days
	54	8	7

IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Beth. Steel Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Jos. H. Lane

11 BIRTHPLACE OF FATHER (City or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kenney

13 BIRTHPLACE OF MOTHER (city or town) Hollins (State or country) Md.

14 Informant Hospital Record (Address)

15 Filed AUG 19 1929, 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15 19 29

17 I HEREBY CERTIFY, That I attended deceased from 8/14, 1929, to 8/15, 1929, that I last saw him alive on 8/15, 1929, and that death occurred, on the date stated above, at 2:17 P.m.

The CAUSE OF DEATH* was as follows:

Acute Hepatitis
Chronic Nephritis
Pneumonia.

Contributory (Secondary) Uremia

(duration) 14 hours

When was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Geo. A. Youngstrom, M. D.

(Address) Md. General Hospital

*State of Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Cemetery	Aug 19 19...
20 UNDERTAKER	ADDRESS
Jno Christian Miller	5337 Jefferson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 48569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

E 48569 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Hetzleman

(a) RESIDENCE NO. 2218 Pinkney ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): (Single)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 22 1929.

7 AGE: Years — Months — Days 26 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry Hetzleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ~~Esther~~ Sophia Kaufman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) 1439 E. Baltimore St.

15 Filed AUG 19 1929, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-19 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1929, to Aug 19, 1929, that I last saw h[illegible] alive on Aug 17th, 1929, and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis (Secondary)

Sarcoma (of Retroperitoneal pelvic tissue)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) H. A. Stowe M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Rosedale — DATE OF BURIAL 8-21 1929

20 UNDERTAKER Jack Lewis, 1434 E Balto St — ADDRESS

N. B.—WRITE PLAINLY, WITH PENCIL OR INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48570

REGISTERED NO. **E 48570**

1-PLACE OF DEATH

City of BALTIMORE: (No. 1624 Harlem Ave 6-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie M Grant

(a) RESIDENCE NO. 1624 Harlem Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James M Grant

6 DATE OF BIRTH (month, day, and year): Oct 15, 1891

7 AGE — Years: 37 — Months: 10 — Days: 2 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse 048

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore, Md

(State or country)

PARENTS

10 NAME OF FATHER: Niles P Sellman

11 BIRTHPLACE OF FATHER (city or town): Sweden

(State or country)

12 MAIDEN NAME OF MOTHER: Mary A Wigley

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant: James M Grant (Husband)

(Address) 1624 Harlem Ave

15 Filed AUG 19 1929 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-17-29 19

17 I HEREBY CERTIFY, That I attended deceased from July, 1928, to Aug. 17th, 1929, that I last saw her alive on Aug 17th, 1929, and that death occurred, on the date stated above, at 11.20 4 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings & History

(Signed) Alex D Schmidt M. D.

8/19/1929 (Address) 713 August St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. Date of Burial 8-20 1929

20 UNDERTAKER: Mrs Chas A G Rohde ADDRESS 2327 Edmondson Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.—WRITE PLAINLY WITH UNFADING INK.—THIS

Spec.—2-29-28—L. F. S.—500 Blks.

E 48571 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48571

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 537 Vincent St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriett Mears

(a) RESIDENCE NO. 537 Vincent St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Wells Cove Md.

PARENTS

10 NAME OF FATHER: James Mears.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Harriett Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Morez Haines. (Address) 537 Vincent St.

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 16 Aug 28

17 I HEREBY CERTIFY, That I attended deceased from 8/16, 19 28, to 8/16, 19 28, that I last saw h... alive on 8/16, 19 28 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (according to History) She was sick for about

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis & Pleurisy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical Exam

(Signed) J. H. Walters, M. D.

19 (Address) 1510 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 8-19 1928

20 UNDERTAKER: Edward Easton — ADDRESS 946 Pa ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-001

E 48572

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Lyderhan Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Latorro

(a) RESIDENCE NO. 1008 E. Pratt St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. — ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 16 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joe Latorro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Gabriele

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joe Latorro

(Address) 1008 E. Pratt St.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 . 1929 to Aug 17 . 1929 that I last saw h alive on Aug 17 . 1929 and that death occurred, on the date stated above, at 6:25 p.m.

The CAUSE OF DEATH* was as follows:

Diphtheria — (Laryngeal)

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Acute Diph Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1008 E. Pratt St.

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Kirby M.D.

8-18 1929 (Address) Lyderhan Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 19, 1929

20 UNDERTAKER Frank V. Pepi Sons

ADDRESS 2515 E. Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 19 1929

Spec.—1-10-21—M&T—1500 Bks.

E 48573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60-001 E 48573

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Sinai Hosp. ST. 90-26 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine F. Krauff.

(a) RESIDENCE No. 1932 N. Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos E Krauff

6 DATE OF BIRTH (month, day, and year): Aug 8- 1880

7 AGE: Years 49 | Months — | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: William Kinney

11 BIRTHPLACE OF FATHER (city or town) (State or country): California

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Ida E Krauff

(Address) Lansdowne Baltimore Md

15 Filed AUG 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/16 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/10 1929 to 8/16 1929

that I last saw her alive on 8/16 1929

and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Thyrotoxicosis

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? yes. Date of 8/13/29

Was there an autopsy? yes.

What test confirmed diagnosis? Physical Exam. & Autopsy

(Signed) A. D. Elbon M. D.

8/16, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Ann — DATE OF BURIAL 19 Aug 20 29

20 UNDERTAKER: Robert Brookerson — ADDRESS Baltimore Holland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 48574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68 V

E 48574
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5 S Dep 2 W 10-13 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank A. MORRIS

(a) RESIDENCE NO 1215 n Eden St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ELLA. M. MORRIS

6 DATE OF BIRTH (month, day, and year) Feb 10 - 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehen Steel Co

9 BIRTHPLACE (city or town)

(State or country) Frostburg Md

PARENTS

10 NAME OF FATHER Frank Morris

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Frostburg Md

12 MAIDEN NAME OF MOTHER Anna Sears

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Frostburg Md

14 Informant Mrs Ella M. Morris

(Address) 1215 n Eden St M. D.

15 Filed AUG 19 1929 C. HAMPSON JONES, M. D.

Ref. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Trauma Orchitis (Cord)

Contributory Convulsions (duration) yrs. mos. 1 ds.

Injuries Received Aug 14 1929 Shades yrs. mos. 1 hr

(Coroner) M. D.

19 (Address) 1438 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Acm Date of Burial 8/20 1929

20 UNDERTAKER Robert Brooks & Son ADDRESS Catham Hollins

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48575

1-PLACE OF DEATH

City of Baltimore: (No. 2617 E Monument St., 7-10 Ward)

2-FULL NAME Mary I Hunt

(a) RESIDENCE NO. 2617 E Monument St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

188-103

E 48575

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: W | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo W. Hunt

6 DATE OF BIRTH (month, day, and year): Apr 23 - 1852

7 AGE: Years 77 | Months 3 | Days 24 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, professinn or particular kind of work: Housework
(b) General nature nf industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Robert Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant: Fannie M Blume
(Address) 2617 E Monument St

15 Filed AUG 19 1929, 19 C. HAMPSON JONES, M. D. Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

THE CAUSE OF DEATH* was as follows:
Broncho Pneumonia
Run down by automobile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Fracture, Hip and Internal Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Mills + Monument St.

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) J. J. Francis, M. D.

, 19 (Address) 2939 W Eddy

*State the Disease Causing Death, nr in deaths frnm Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: 8/20 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48576

CERTIFICATE OF DEATH

74-001

E 48576

1-PLACE OF DEATH

City of Baltimore: (No. 720 W. Stockholm St. 21-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis B. East

(a) RESIDENCE NO. 720 W. Stockholm St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary B. East

6 DATE OF BIRTH (month, day, and year) Sept. 12-1869

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	59	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Piano Mover
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER John East

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine White

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mamie Bealefeld
(Address) 2227 Annapolis Ave

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar
For

AUG 19 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.

8/19. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Aug. 20 1929
20 UNDERTAKER Wm. Cook	ADDRESS 1217 St. Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Hessen Poteau Park Rd

E 48577

CERTIFICATE OF DEATH

1334 N

E 48577

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 North Milton Ave St. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Arthur

(a) RESIDENCE NO. 1623 N. Milton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E Arthur

6 DATE OF BIRTH (month, day, and year) Feb 4-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Fred Spindler

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Samuel Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County

12 MAIDEN NAME OF MOTHER Martha Ayers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford County

14 Informant Mrs M. Arthur

(Address) 1623 N. Milton Ave

15 Filed ....., 19 .... C. HAMPSON JONES Registrar

AUG 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1929, to Aug 17, 1929, that I last saw h im alive on Aug 17, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) E. E. Reaver, M. D.

Aug 18, 1929 (Address) 1307 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug 21 1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Mary E. Merritt

E 48578

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 48578

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 16-67

CITY OF BALTIMORE: (No. 2940 Mosher ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ellen Merritt

(a) RESIDENCE NO. 2940 Mosher ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Merritt

6 DATE OF BIRTH (month, day, and year) Sept 23, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of indastry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm W Asher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann E Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John J. Merritt

(Address) 2940 Mosher St.

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1927, 19..., to Aug 11, 19 29.

that I last saw he alive on Aug 14, 19 29

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arth - intoxication

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination personal

(Signed) H. H. Stansbury, M. D.

Aug 19. 1929 (Address) 714 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug. 19 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 E. Pratt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48579 HEALTH DEPARTMENT—CITY OF BALTIMORE 88-10 **E 48579**

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St. 11-24 Ward)

2-FULL NAME Cornelius James

(a) RESIDENCE NO. 1219 McCulloh St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Martha James

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	43	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Cornelius James

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Irene Grant

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Martha James
(Address) 1219 N. McCulloh St

15 Filed AUG 19 1929 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Pelvis
Shock at intussusception of
many automobiles

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Clinton & Bolton

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

8 (Signed) W. D. Frame M. D.
17, 19 (Address) 2937 N. McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Castle Va.	Aug 19 1929
20 UNDERTAKER Mrs P. V. Elliott	ADDRESS 1925 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 48580

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48580

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument, Rutland ST., 1-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Bamberger

(a) RESIDENCE NO. Sinai Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~~Widowed~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	91	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Schebach

(State or country) Bavaria Germany

PARENTS

10 NAME OF FATHER Isaac Bamberger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Babetta Frew

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Dr. Edgar Friedenwald

(Address) Lincoln Bldg.

15 Filed AUG 19 1929, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 18, 1929.

that I last saw her alive on Aug 18, 1929,

and that death occurred, on the date stated above, at 3.10 p. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerotic C.V. disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. history & findings

(Signed) Jacob H. Conn, M. D.

Aug 18 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Taken to Hebrew Cem	8/20 1929

20 UNDERTAKER Harris Sondheim

ADDRESS W. Fay. nat. Lloyd Ave

AUG 19 1929

mation should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 48581

CERTIFICATE OF DEATH

E 48581

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ——— ST. 14 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Richardson.

(a) RESIDENCE NO. 1401 Wilmer Alley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Richardson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER David Richardson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Priscilla Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Records,
(Address) Baltimore City Hospitals.

15 Filed AUG 19 1929 19 H. BRUNO JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1929, to Aug 17, 1929, that I last saw h. alive on Aug 17, 1929 and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Syphilis ? aorta with aortic insufficiency.
Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Private at home
secondary in hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Harold W. Wilson M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	8/20 1929
20 UNDERTAKER	ADDRESS
Saml. W. Chase & Son	1403 Monroe

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48582

CERTIFICATE OF DEATH

E 48582

1—PLACE OF DEATH 108 W. Lee St. REGISTERED NO.

CITY OF BALTIMORE, (Co.) ST. 22-30 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L. Fahndrich

(a) RESIDENCE NO. 108 W. Lee ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Max A. Fahndrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eleanor Scanlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Eleanor Fahndrich

(Address) 108 W. Lee St

15 Filed AUG 15 1929, 19 [illegible] C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/29

17 I HEREBY CERTIFY, That I attended deceased from 8/13, 1929, to 8/17, 1929, that I last saw her alive on 8/17, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Hemangioma Hemorrhage in the Newborn.

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Wassermann ++ (cancer) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) David Drawbaugh M. D.

1929 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 19 1929

20 UNDERTAKER Margaret J. Flynn ADDRESS 122 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 48583

E 48583

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 3603 Harlem Ave St. 16-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Marriott

(a) RESIDENCE NO. 3603 Harlem Av St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. – mos. – ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married.

5a If married, widowed, or divorced
BUSBAND of (or WIFE of) Sarah A Marriott.

6 DATE OF BIRTH (month, day, and year) May 12-1864.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	65	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City.

(c) Name of employer " "

PARENTS

9 BIRTHPLACE (city or town) Baltimore Co,

(State or country) Maryland.

10 NAME OF FATHER Wm. H. Marriott

11 BIRTHPLACE OF FATHER (city or town) Balto Co

(State or country) Md.

12 MAIDEN NAME OF MOTHER Priscilla Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto Co,

(State or country) Maryland.

14 Informant Sarah A. Marriott

(Address) 3603 Harlem av

15 Filed....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17- 1929.

17

I HEREBY CERTIFY, That I attended deceased from June 1- 1928, to Aug 17- 1929, that I last saw him alive on Aug - 15 - 1929, and that death occurred, on the date stated above, at 12:40 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma

(duration) – yrs. 14 mos. – ds.

CONTRIBUTORY (Secondary) none

(duration) – yrs. – mos. – ds.

18 Where was disease contracted

If not at place of death! unknown.

Did an operation precede death! no Date of –

Was there an autopsy! no

What test confirmed diagnosis! physical signs

(Signed) Chester Riland, M. D.

8-17- 1929 (Address) 2532 Edmondson Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Aug 19 1929

20 UNDERTAKER George J Smith ADDRESS 1532 Hollins

WHITE PRINTING, WITH CAPABILITY FOR—THIS IS A LEGAL RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SG [illegible] HAMILTON JONES M D

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48584

E 48584
REGISTERED NO.

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 338 Dover St. 22-30 Ward)

2-FULL NAME William Hughes

(a) RESIDENCE NO. 338 Dover St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	about 42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) —

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)
(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant
(Address)

15 Filed 19
Registrar

AUG 19 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis
Duration yrs. mos. ds.
CONTRIBUTORY (Secondary)
Exhaustion
Duration yrs. mos. ds.
Aug 18/29 Signed G C Yates M. D.
(Coroner)
, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
UNIVERSITY OF MARYLAND 19

20 UNDERTAKER — ADDRESS
[redacted] Issuing Agent
AUG 19 1929

C. HAMILTON JONES, M. D.

U. S.—WHITE PAPER, WHEN ORDERING ADDITION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

E 48585 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48585

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Johnson ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Bennett Stone

(a) RESIDENCE No. 1613 John st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Stone

6 DATE OF BIRTH (month, day, and year) Dec 28-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	81	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John W. Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Lokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alan P. F. Watkins

(Address) 1613 Johns st

Filed Aug 19 1929 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1929, to Aug 18, 1929, that I last saw h alive on Aug 18, 1929, and that death occurred, on the date stated above, at 7-P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) John A. Fraley, M. D.

(Address) 43. Preston st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cem. Md DATE OF BURIAL Aug 20 1929

20 UNDERTAKER Chas. E. Isaac ADDRESS 802 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG

Spec.—1-10-21—M&T—1500 Bks.

E 48586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48586

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Nonument and Rutland 6-16 WARD)

2-FULL NAME Jacob Weinstein.

(a) RESIDENCE NO. 1601 N. Milton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Sophia Weinstein

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sophia Weinstein

(Address) 1601 N. Milton ave.

15 Filed AUG 19 1929 C. HARRISON JONES, M. D. Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1929

17

I HEREBY CERTIFY, That I attended deceased from July 17. 1929. to aug 18 1929.

that I last saw him alive on aug 18 1929,

and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Chr. Cardiac dilatation & congestive cardiac failure

(duration) unk yrs. mos ds.

CONTRIBUTORY (Secondary) asthma

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unk

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical hist & findings

(Signed) Jacob N. Cony M. D.

8/18 19 29 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem DATE OF BURIAL 8/20 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48587

CERTIFICATE OF DEATH

129

E 48587

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2052 E Hoffman ST. 8-17 WARD)

2—FULL NAME Edna Baker

(a) RESIDENCE NO. 2052 E Hoffman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dont know

7 AGE: Years 55 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John T. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Sarah M Degnan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Mrs Annie L Baker

(Address) 2052 E Hoffman St

15 Filed Aug 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17-1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Aug 17, 1929, that I last saw her alive on Aug 17, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hugh H. L. Miller, M. D.

8-19, 1929 (Address) 3325 E Balt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Aug 20, 29

20 UNDERTAKER: John Ulrich

ADDRESS: 208 Belair

G3

IMPORTANT—Write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

E 48588

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 N. Calhoun St., 16-23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adell Parker

(a) RESIDENCE NO. 705 Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ...

6 DATE OF BIRTH (month, day, and year): Oct 18 1913

7 AGE: Years 15 Months 9 Days 28 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): N.C.

PARENTS

10 NAME OF FATHER: Z. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Blannie Ballard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Blannie Parker
(Address): 705 Calhoun St

15 Filed ... 19 ... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/16 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/3 , 1924 , to 8/16 , 1924 .

that I last saw him alive on 8/16 , 1924

and that death occurred, on the date stated above, at 9.20 A.M.

The CAUSE OF DEATH* was as follows: Sarcoma of Neck

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Emil Klotz, M. D.

8/16, 1924 (Address) 2139 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Aug. 19, 1924

20 UNDERTAKER: Mrs. Kate R. Williams — ADDRESS 3224 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

AUG 19 1924

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48589

CERTIFICATE OF DEATH.

101-001

E 48589

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital WARD 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L Hooker

(a) RESIDENCE No. 833 N Bond St, Upper Fort WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Friend (Address): City

15 Filed AUG 19 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 18, 1929, that I last saw h[illegible] alive on Aug 18, 1929, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? X-Ray & Autopsy

(Signed) Geo. McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pendleton Va.	Aug 19 1929
20 UNDERTAKER	ADDRESS
J L Brown & Son	10 Y St Navy

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

C. HAMILTON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 48590

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3110 Strickland ST. 20-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William R. Kohlenberg

(a) RESIDENCE NO. 3110 Strickland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen M. Kohlenberg

6 DATE OF BIRTH (month, day, and year) April 13 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	4	√	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 0 3 √

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City Fire Dept

9 BIRTHPLACE (city or town) Barthlows
(State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER Daniel Berry Augustus Kohlenberg

11 BIRTHPLACE OF FATHER (city or town) Buckeystown
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Murphy

13 BIRTHPLACE OF MOTHER (city Barthlows
(State or country) md

14 Informant Laura A. Lee
(Address) 2717 Oak St

15 Filed C. HAMPSON JONES, M. D. 19
Registrar

G 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 15 . 1929 . to Aug 18 . 1929

that I last saw him alive on Aug 18 . 1929

and that death occurred, on the date stated above, at 5-45- P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl. & Phy Exam

(Signed) J. J. Kyper M. D.

. 19 (Address) 3321 Fredrick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	aug 21 1929
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48591

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48591

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital 17-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Granville Jamal

(a) RESIDENCE NO. 703 Penn. ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work C laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant friend
(Address)

15 Filed 9 1929 C. HAMPSON JONES, M. D. Registrar

Path. Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 17, 1929, that I last saw h(im) alive on Aug 17 4:40 PM and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardiac Decompensation

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington DC

DATE OF BURIAL Aug 19 1929

20 UNDERTAKER James E. Wright

ADDRESS 664 Harrison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48592

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48592

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-67

CITY OF BALTIMORE: (No. 1803 Chelsea Road St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm A. Peckocheck

(a) RESIDENCE NO. 1803 Chelsea Road St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Peckocheck

6 DATE OF BIRTH (month, day, and year) Aug 23-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D. C.
(State or country)

PARENTS

10 NAME OF FATHER Albert Peckocheck

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Ann Courtney

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Ann M. Rickette
(Address) 1803 Chelsea Road

15 Filed 19 1929 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18/29

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1929, to Aug 18, 1929, that I last saw him alive on Aug 17, 1929, and that death occurred, on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of throat about 9 mos.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of throat about 9 mos.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test

(Signed) Walter S Nisbett, M. D.

Aug 18/29 (Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/20 1929
20 UNDERTAKER	ADDRESS
Chas E. Ware & Son	1 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. EXACT RESIDENCE OF DECEASED is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2 E 8928 48593 — 38 B 48593

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernard Jones

(a) RESIDENCE NO. 1407 Ethsing ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Sngl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/9/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ny

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Nellie Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 8 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-16-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1929, to Aug. 16, 1929, that I last saw him alive on Aug 16, 1929, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Laparotomy (Appendicitis) - type unknown

about (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumococcal Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) B. S. Hodges, M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 8-20 1929

20 UNDERTAKER D. Hunt Easton — ADDRESS 916 Eutaw

OF DEATH in plain terms, so that it may be property classified. Exact statement of occupation is important. See instructions on back of certificate.

G 19 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48594

E 48594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2918 St. Paul St. 17-50 WARD)

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Startzman Griffith

(a) RESIDENCE NO. 2918 St. Paul ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George M. Griffith

6 DATE OF BIRTH (month, day, and year) May-19-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Startzman

11 BIRTHPLACE OF FATHER (city or town) ? ?

(State or country) United States

12 MAIDEN NAME OF MOTHER Mary A. Kraft

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) United States

14 Informant Mr. George M. Griffith (husband)

(Address) 2918 St. Paul St. Balt.

Filed AUG 19 1929 C. HAMPSON JONES, M. D. Registrar

BY ____ Rpt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 14. 1929. to Aug. 19. 1929.

that I last saw her alive on Aug 19 1929

and that death occurred, on the date stated above, at 8:45 a. m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) (?) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) A. J. P. Triplett, M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery.

DATE OF BURIAL August 21st 1929

20 UNDERTAKER STEWART & MOWEN COMPANY

WILLIAM F. WOOSER, Secretary

ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 48595 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48595

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 N Chester St. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lorenz Ruehl

(a) RESIDENCE NO. 1734 N Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie M. Ruehl

6 DATE OF BIRTH (month, day, and year) Sept. 6. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	69	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Frescoe Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1 year

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Minnie M. Ruehl (Wife)
(Address) 1734 N. Chester St.

15 Filed ..... 19 ..... G. HAMPSON JONES, M. D. Registrar
By .....

AUG 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 18, 1929, that I last saw him alive on Aug 17, 1929, and that death occurred, on the date stated above, at 5⁴⁵ a m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction, Tympanites

Dyspnea.

of intestines (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Sigmoid?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. C. Carman, M. D.

8 18 1929 (Address) 1201 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Paul's Cemetery	Aug. 21 1929
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	Baltimore St. & Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48596 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

123 E 48596

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert W. Chesney

(a) RESIDENCE NO. 1517 Covington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Amelia J. Chesney

6 DATE OF BIRTH (month, day, and year) October 10, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	54	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 6 years.

(c) Name of employer Baltimore & Ohio Railroad

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Samuel Chesney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Alberta. Walker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Samuel M. Chesney (Son)

(Address) 2504 Hermosa St Hamilton

15 Filed AUG 19 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19 1929

17

I HEREBY CERTIFY, That I attended deceased from 8/14, 1929, to 8/19, 1929,

that I last saw him alive on 8/19, 1929,

and that death occurred, on the date stated above, at 12 20 p. m.

The CAUSE OF DEATH* was as follows:

Cholangitis - Cholelithiasis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage 1 hr

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Yes Date of 8/17/29

Was there an autopsy? no Removal of Gall Bladder

What test confirmed diagnosis? clinical

(Signed) Chas. B. Wallace M. D.

, 19 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Aug 22 1929

20 UNDERTAKER Henry Sander & Sons, Inc. — ADDRESS Baltimore St & Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 48597 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 **E 48597**

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 3904 E. Fait ave ST. [illegible] WARD 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincent G. Otto

(a) RESIDENCE NO. 3904 E Fait ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose M. Otto

6 DATE OF BIRTH (month, day, and year) Jan 17 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	51	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lead Burner

(b) General nature of industry, business, or establishment in which employed (or employer) Baughman-Bo 086

(c) Name of employer Baughman-Bo Chicago Ill

9 BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10 NAME OF FATHER Andrew Otto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Antoinette [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rose Otto
(Address) 3904 E Fait ave

15 Filed ___, 19 C. HAMPSON JONES, M. D. Registrar

AUG 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 29

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Aug 17, 1929

that I last saw him alive on Aug 17, 1929

and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Chr. Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Joseph Lowber M. D.

. 19 (Address) 806 S. Elwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	8/20/1929
20 UNDERTAKER J. A. Moran	ADDRESS 3002 E. Baltimore

Penalty attached. Last statement of OCCUPATION is important. See instructions on back of certificates. If DEATH in plain terms, so that it may be properly

Spec.—2-29-28—L. F. S.—500 Bks.

E 48598 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48598

CERTIFICATE OF DEATH X 100-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balt City Hosp. ST. 26-37 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank O'Donnell

(a) RESIDENCE NO. Chase Park Rd. ST. WARD Brooklyn N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Hugh O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Hospital Record
(Address)

15 Filed 8/19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17/29

17 I HEREBY CERTIFY, That I attended deceased from 8/15, 1929, to 8/17, 1929

That I last saw him alive on 8/17, 1929

and that death occurred, on the date stated above, at 9/40 a.m.

The CAUSE OF DEATH* was as follows:

Cellulitis of anterior portion of neck

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 8/16/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. O. Lumpkin, M. D.

8/18, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenlawn Cem. Brooklyn, N.Y.	8/20 1929
UNDERTAKER J. J. Moran	ADDRESS 309 E Balto St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ **E 48599**

E 48599

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore. (Usual place of abode) Rear 4118 Sherbrook Ave 7-17 (Ward)

2-FULL NAME Jos. Kyzour.

(a) RESIDENCE NO 831 N. Bellingtown Ave Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Kyzour

6 DATE OF BIRTH (month, day and year): May 13 1860

7 AGE: Years 64; Months 8; Days 2; IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Seat Bldg
(b) General nature of industry, business, or establishment in which employed (or employer): Hobbs Co.
(c) Name of employer

9 BIRTHPLACE (city or town): Bohemia
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Frances Kyzour
(Address) 831 N. Bellington Ave

15 Filed AUG 17 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sequelae

(Signed) H. C. Hampson Jones, M. D.

Aug 19 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Augs 19 29

20 UNDERTAKER: Grant Coach Son — ADDRESS: 1900 Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48600

CERTIFICATE OF DEATH.

124

E 48600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 2-4 (WARD)

2-FULL NAME Brandel Herzberg

(a) RESIDENCE NO. 1815 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 9 mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Abraham Herzberg

6 DATE OF BIRTH (month, day, and year) Feb. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dynow Poland

PARENTS

10 NAME OF FATHER Israel Isaiah Fish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dynow Poland

12 MAIDEN NAME OF MOTHER Selda Kirsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Isaac Herzberg

(Address) 1815 E. Baltimore St.

15 Filed , 19 [illegible] Registrar

C. HARRISON JONES, M. D.

UG 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug. 19, 1929, that I last saw h alive on Aug 19, 1929, and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hemiplegia Cerebral

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 5, 1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. R. Kaufman, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodelph	8-20 1929
20 UNDERTAKER	ADDRESS
Jack Levin 1434	E Balto 20

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

109-002

E 48601

CERTIFICATE OF DEATH

E 48601

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3703 Forest Park Ave ST. 5-6 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helene A. Prince

(a) RESIDENCE NO. 3703 Forest Park Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 45 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21-1883

7 AGE: Years 45 | Months 8 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Shipping Dept

(c) Name of employer: Schoen & Co

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Conrad Prince

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Carolyn Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Robert Prince

(Address) 3703 Forest Park Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

UG 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 18-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1929, to Aug. 18, 1929, that I last saw h.. alive on Aug. 18 1929 and that death occurred, on the date stated above, at 4 50 P. m.

The CAUSE OF DEATH* was as follows:

Septic Sore Throat (Streptococcus)

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Signs & Laboratory

(Signed) W. S. Bridell, M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- [illegible] Loudon Park Cem. | DATE OF BURIAL Aug 21 1929

20 UNDERTAKER Wm J Tucker Sons | ADDRESS N. & Pa.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48602 HEALTH DEPARTMENT—CITY OF BALTIMORE ~~10-001~~ **E 48602**

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 16

CITY OF BALTIMORE: (No. Sydenham Hospital WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME RAYMOND KECKNER

(a) RESIDENCE NO. Cockeysville, Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. 3 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 21, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Home 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cockeysville Md

PARENTS

10 NAME OF FATHER Allen Keckner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cockeysville Md

12 MAIDEN NAME OF MOTHER Susie Lindeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cockeysville Md

14 Informant Allen Keckner
(Address) Cockeysville Md

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Aug 18, 1929, that I last saw h alive on Aug 18, 1929 and that death occurred, on the date stated above, at 4 45 p.m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Laryngeal, Tonsillar & Nasal)

(duration) 0 yrs. 0 mos. 6 da.

CONTRIBUTORY (Secondary) Acute Diphtheritic Myocarditis (duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Cockeysville, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & culture

(Signed) Addison Craft Isky, M. D.

8-19 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerrows Cem., Cockeysville, Md	Aug 20 1929
20 UNDERTAKER	ADDRESS
Wm C Burdett & Son	Sparks, Md.

important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48603

CERTIFICATE OF DEATH

E 48603

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 845 McKim St. 10-1-F Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Wright

(a) RESIDENCE NO. 845 McKim St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 8/ 1881

7 AGE: Years 48 Months Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: None

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Annie Wright, Daughter

(Address) 845 McKim St. City

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to Aug 16, 1929, that I last saw her alive on Aug 16, 1929, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ch. Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein, M. D.

8/19, 1929 (Address) 738 Wiquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. Date of Burial Aug 20 1929

20 UNDERTAKER: Chas. H. Johnson ADDRESS 416 N. Carolina

UG 20 1929 C. HAMPSON JONES M. D.

U. S.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9 **E 48604**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 John St ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Josephine Perkinson

(a) RESIDENCE NO. 1516 John St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 16 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John P. Perkinson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E Meiner

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant John. P. Perkinson

(Address) 1516 John St

15 Filed G 20 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19. 1929.

17

I HEREBY CERTIFY. That I attended deceased from Aug. 18, 1929, to Aug 19, 1929

that I last saw her alive on Aug 19, 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

(3) Bronchio Pneumonia

(2) Anaemia - Malnutrition

(1)

CONTRIBUTORY (Secondary) Whooping Cough (duration) yrs. mos. 2 ds.

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted If not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas. J. A. Stevens, M. D.

8/19/29 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery — DATE OF BURIAL Aug. 20. 19 29

20 UNDERTAKER Margaret E. Flynn — ADDRESS 1111 Gold St.

• IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 48605

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 W. Pratt ST. 70-28 WARD)

2-FULL NAME Catherine Schek

(a) RESIDENCE NO. 1917 W. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles F. Schek.

6 DATE OF BIRTH (month, day, and year): Oct. 27-1842

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
86	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: George Betger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Katie Schek (Address) 1917 W. Pratt St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 18, 1929, that I last saw him alive on Aug 17, 1929, and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

CONTRIBUTORY (Secondary) Cl. Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

8/20/29 (Signed) Roy McGinn M. D.

(Address) 405 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: aug 20 1929

20 UNDERTAKER: Forsch Leyer

ADDRESS: 1600 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48606
1—PLACE OF DEATH

CERTIFICATE OF DEATH

138 E 48606

CITY OF BALTIMORE: No. Mt Gun Hosp X. ST. 15-66 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise McCann

(a) RESIDENCE NO. 3214 Garrison Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Mrd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/4/1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER John McCann
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md
12 MAIDEN NAME OF MOTHER Annie VanBorne
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant
(Address) Hospital Records

15 Filed AUG 20 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20/29

17 I HEREBY CERTIFY, That I attended deceased from 8/4/29, 19, to 8/20/29, 19, that I last saw h alive on 8/20/29 and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH was as follows:
Acute Ch Interstitial Laryngitis
Acute Ch Asphyxia

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia, Chronic Endocarditis (duration) 1 yrs. mos. ds.

18 Where was disease cantracted if not at place of death? Home

Did an operation preceda death? Yes Date of 8/19/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John B Emerson, M. D.

(Address) 710 Mt Gun Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cem — DATE OF BURIAL Aug 22 29

20 UNDERTAKER John Burns Sons — ADDRESS Towson Md

OF DEATH in plain terms, so that it may be properly classified. Each statement of cause is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48607

CERTIFICATE OF DEATH

31 ✓

REGISTERED NO. E 48607

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1652 Warwick Ave ST. 5-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen B. Williams

(a) RESIDENCE NO. 1652 Warwick Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin H. Williams

6 DATE OF BIRTH (month, day, and year) Oct 31, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry J. Knoch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Bertha Gramlich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edwin H. Williams

(Address) 1652 Warwick Ave.

15 Filed ....., 19 .... Registrar

AUG 20 1929 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18/29.

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to Aug 18, 1929,

that I last saw h.e alive on Aug 18, 1929

and that death occurred, on the date stated above, at 3.24 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) L. L. Wring, M. D.

Aug 19, 1929 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Aug 21, 1929.
20 UNDERTAKER	ADDRESS
Mr & Mrs. John W. Teufel & Son	805 W. Fayette

Directions for filling out certificates.

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48608

CERTIFICATE OF DEATH

109-002

E 48608

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 27-44 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Katherine E. Storm

(a) RESIDENCE NO. 3306 Schodale Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced (or) WIFE of John A. Storm

6 DATE OF BIRTH (month, day, and year) Apr. 5, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39	yrs	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia (State or country)

PARENTS

10 NAME OF FATHER Harry Kyle

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Gibbons

13 BIRTHPLACE OF MOTHER (city or town) Phila (State or country) Pa

14 Informant Hospital Records

(Address)

15 Filed AUG 29 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19/29

17 I HEREBY CERTIFY, That I attended deceased from 8-16, 1929, to 8/19, 1929

that I last saw her alive on 8/19 1929

and that death occurred, on the date stated above, at 1 10 PM.

The CAUSE OF DEATH* was as follows:

Neoplasm
Uterus Media
Insidiitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute cardiac dilatation

(duration) yrs. mos. 1 Hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Malignancy 8/16/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Leyhe, M. D.

8/21, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arridental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 22 1929
20. UNDERTAKER Wm J Tucker Sons	ADDRESS North & Pa

OF DEATH in plain terms, so that it may be properly classified. STATISTICAL. LEGAL STATEMENT OF OCCUPATION IS ALSO important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48609

CERTIFICATE OF DEATH

100-001

E 48609

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 4000 Maura ST., 15-64 WARD)

2—FULL NAME Emma Gilpin Prentiss

(a) RESIDENCE NO. 4000 Maura Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel H Prentiss

6 DATE OF BIRTH (month, day, and year): Feby 6 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): York Penna

PARENTS

10 NAME OF FATHER: Gilpin

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Chas H Prentiss
(Address) 4000 Maura

15 Filed AUG 20 1929 J. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17-1929

17 I HEREBY CERTIFY, That I attended deceased from July 31st, 1926, to Aug 17th, 1929, that I last saw her alive on Aug 17th, 1929, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Senility - Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia & Bronchial Pneumonia - (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) M. P. Byerly, M. D.

19 (Address) 304 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Aug 21 1929

20 UNDERTAKER: [illegible] — ADDRESS: Northern

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48610

CERTIFICATE OF DEATH

129 E 48610

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1348 E. Fort Ave (St.) 24-33 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Leimbach

(a) RESIDENCE NO. 1348 E. Fort Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Emma Leimbach

6 DATE OF BIRTH (month, day, and year) Feb. 9 - 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Emma Leimbach

(Address) 1348 E. Fort Ave

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17-1929

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1929, to August 17, 1929, that I last saw h-- alive on August 16, 1929 and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Primary Arteriosclerosis - Sclerosis chronic. Interstit. Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. E. Marx M. D.

8/19, 1929 (Address) 336 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem	Aug 21 1929
20 UNDERTAKER	ADDRESS
Wm J Tickner Sons	N. Y. Pa.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Hosps.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48611

CERTIFICATE OF DEATH

× 202

E 48611

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 11-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Francis J. Herbert

(a) RESIDENCE NO. 604 St. Paul St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ellen Herbert

6 DATE OF BIRTH (month, day, and year) Jan 15-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 yrs	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Ornamental

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Miss.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Mrs. Ellen Herbert.

(Address) Cleveland Ave

15 Filed AUG 20 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/29.

17

I HEREBY CERTIFY, That I attended deceased from 8-15, 1929, to 8-18, 1929, that I last saw h[illegible] alive on 8-18, 1929 and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Left Axillary abscess extending to Chest wall (Left)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 8-17-29

Was there an autopsy? No Drainage of abscess.

What test confirmed diagnosis? Clinical Test.

(Signed) J B Hundley M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cleveland	Aug 20 19 29
20 UNDERTAKER Geo. H. Lutz	ADDRESS 2708 Edmondson

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48612 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48612

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. 2129

CITY OF BALTIMORE: (No. University Hospital ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Griffin, Richard.

(a) RESIDENCE NO. 501 Wyeth St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elenor Griffin

6 DATE OF BIRTH (month, day, and year) Feb 10, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Theresa Hinkelbein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Ruth Jones

(Address) 511 Wyeth St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1929, to Aug. 19, 1929, that I last saw him alive on Aug. 19, 1929, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Nephritis - Chronic

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis. Pericarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Analysis, Blood Chemistry

(Signed) M. C. Barnfield, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL 8/22/29, 19

20 UNDERTAKER W. W. Cook ADDRESS Park Circle

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48613 — CERTIFICATE OF DEATH — E 48613

1-PLACE OF DEATH: City Hospital, [illegible] St., [illegible] Ward) — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: James W. Stinchcomb

(a) RESIDENCE NO. 2704 Elliott St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced — HUSBAND of (or) ~~WIFE of~~: Nola Stinchcomb

6 DATE OF BIRTH (month, day, and year): April 22nd 1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	3	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer): A. P. Store Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm Stinchcomb

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elsa Hill

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant: Nola Stinchcomb
(Address) 2704 Elliott St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH was as follows:

* Fight Homicide
Fracture of Skull

(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

, 19 (Address) 1432 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old Town Cemetery	Aug 21st 1929
20 UNDERTAKER	ADDRESS
Kelly & Geier Inc.	[illegible]

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Sarah A T. Covington

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48614

CERTIFICATE OF DEATH

129 E 48614

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2506 (St.) Gilsa Ave (27-H WARD)

2—FULL NAME Sarah A. T. Covington

(a) RESIDENCE NO. 2506 (Usual place of abode) Gilsa Ave ST., ... WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced (HUSBAND) of (or) WIFE of Sarah A. T. Covington

6 DATE OF BIRTH (month, day, and year) Aug. 14 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md.

PARENTS

10 NAME OF FATHER Wm. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Mrs Joseph G. Sutton

(Address) 2506 Gilsa Ave

15 Filed ..... 19 ..... Registrar

AUG 20 1929 HAMPSON JONES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1929

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to Aug 19, 1929, that I last saw h[illegible] alive on Aug 15, 1929, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Uraemia

Chronic Interstitial Nephritis (duration) 5 mos. ds.

CONTRIBUTORY (Secondary) (duration) 5 yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John J. Tech, M. D.

8/19, 1929 (Address) 936 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Grove Cemetery	Aug 21 19 29
20 UNDERTAKER	ADDRESS
Penny Noel & Sons Inc	1301 E Eager

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48615

CERTIFICATE OF DEATH

113

E 48615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1004 N. Arlington St. 16-23 Ward)

2-FULL NAME Henry L. Brown

(a) RESIDENCE NO. 1004 N. Arlington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25 - 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Jas. L. Brown

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Annie Coates

13 BIRTHPLACE OF MOTHER (city or town) Georgia
(State or country)

14 Informant Annie Brown
(Address) 1004 N. Arlington St

15 Filed AUG 31 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Bacteriological
(Signed) H. Blunk M. D.
Aug 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	8/31 1929
20 UNDERTAKER	ADDRESS
Lemmt. W. Chase & Son	1418 W. Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 31 1929 H. RANSOM JONES, M. D.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48616

E 48616

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1331 Bolton St. 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. F. Scheuermann

(a) RESIDENCE NO. 509 Walker Av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 12, 1869

7 AGE — Years: 60 — Months: 4 — Days: 5

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): self

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER: Chas Scheuermann

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Anna C. Wenckenroth

13 BIRTHPLACE OF MOTHER (City or town): Germany

(State or country)

14 Informant: Mrs Minnie Scheuermann

(Address) 509 Walker Ave Govans

15 Filed ..... 19 .....

AUG 29 1929 HARRY JOHNS, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Aug 17, 1929, that I last saw h[illegible] alive on Aug 13, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tachycardia

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) ... yrs. ... mos. 1 da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Phys Examn

(Signed) Jas L. Hodges, M. D.

(Address) 862 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park	Aug 20 1929
20 UNDERTAKER: George J. Smith	ADDRESS 153 Holliday

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48617

CERTIFICATE OF DEATH

24

REGISTERED NO. E 48617

1—PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. 12-50 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eleanor B. Herzer

(a) RESIDENCE NO. 3001 Guilford Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 5 mos. 22 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Gustav Herzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sue Roddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr. Gustav Herzer

(Address) 3001 Guilford ave.

15 Filed ....., 19 .... Registrar

AUG 20 1929

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-19-29

17

I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Aug 19, 1929, that I last saw h alive on Aug 19, 1929 and that death occurred, on the date stated above, at 1155 P m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis (duration) yrs. mos. Hrs.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Vincent Messina, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 22 1929
20 UNDERTAKER	ADDRESS
Henry W. Meursdon	805 N. Calvert St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48618

CERTIFICATE OF DEATH

1882 203

E 48618

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hosp St., Ward)

2-FULL NAME Weronika Myslinska

(a) RESIDENCE NO. 6994 Railway ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 4-1918

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	10	8	14 15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer do

9 BIRTHPLACE (city or town) Lawrenceburg
(State or country) Pa

PARENTS

10 NAME OF FATHER Bronislaw Myslinski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Stanislawa Mrzyzynska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Bronislaw Myslinski
(Address) 6994 Railway Avenue

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Ruptura Lienis

Car in which she was riding overturned in ditch

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Fract L. Arm

Hemorrhage (Portal)

(duration) — yrs. mos. da.

18 Where was disease contracted If not at place of death? Belair, Md

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Surgical autopsy

(Signed) S. J. Strauss M. D.

1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart of Mary	Aug 21 1929
20 UNDERTAKER George A. Weber	ADDRESS 705 S Amity

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 48619

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1821 E. North Ave. ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas E. Rutley

(a) RESIDENCE NO. 1821 E. North Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lettitia Rutley

6 DATE OF BIRTH (month, day, and year) Sept. 27 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thomas Rutley

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Anna Ellor

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14

Informant Mrs. Rutley

(Address) 1821 E. North Ave

15

Filed AUG 20 1929, 19 C. HAMPSON JONES, M. D.

Per ALK, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-18-1929

17

I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Aug 19, 1929, that I last saw h— alive on Aug 17, 1929 and that death occurred, on the date stated above, at 2 45 A. M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis & Influenza Infection

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Inflammation Heart

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? non

What test confirmed diagnosis? Clinical

(Signed) R. J. Carman, M. D.

Aug 19, 1929 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	8/21 1929
20 UNDERTAKER	ADDRESS
I. Few McCully	130 E Fort

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48620

CERTIFICATE OF DEATH

159-003

REGISTERED NO. **E 48620**

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 540 Brunswick ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Hitt

(a) RESIDENCE NO. 540 Brunswick ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19 1929.

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jesse Hitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ethel A. Hamel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Jesse Hitt

(Address) 540 Brunswick St

15 Filed ... 19 ... HAMPSON JONES, M. D., Registrar

UG 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19th 29

17 I HEREBY CERTIFY, That I attended deceased (from Aug 19th 1929 to Aug 19th 1929 that I last saw him alive on Aug 19th 1929 and that death occurred, on the date stated above, at 7:25 P.M.

The CAUSE OF DEATH* was as follows:

Spina Bifida

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical only

(Signed) [illegible] M. D.

Aug 20 1929 (Address) 1729 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Aug 21st 1929

20 UNDERTAKER: F. A. Heppard

ADDRESS: 1502 E Baltimore St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48621

CERTIFICATE OF DEATH

76 E 48621

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 8-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Viola Peters

(a) RESIDENCE NO. 246 N. Arlington Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Lord

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address) UN

15 Filed G 20 1929 19 HUMPHREY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16/29

17 I HEREBY CERTIFY, That I attended deceased from 7/1, 1929, to 8/16, 1929

that I last saw her alive on 8/16, 1929

and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Metastases to lungs.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Rumpasis, M. D.

8/16, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
VERSITY OF MARYLAND.	AUG 20 1929

20 UNDERTAKER

ADDRESS

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 48622 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48622

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2810 Kate Av ST. 15-56 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank C. Friedel

(a) RESIDENCE NO. 2810 Kate Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary C. Friedel

6 DATE OF BIRTH (month, day, and year): June 1-1869

7 AGE — Years: 60 Months: 2 Days: 18 If LESS than 1 day, hrs. or min.: 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Manager

(b) General nature of industry, business, or establishment in which employed (or employer): 604

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Friedel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary J. Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary C. Friedel (Address): 2810 Kate Ave

15 Filed ..... 19 ..... Registrar

AUG 20 1929 C. HAMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-19-1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1926, to Aug 19, 1929, that I last saw him alive on Aug 12, 1929, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart disease (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Leo Steele M. D.

8-19-1929 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 8/22 1929

20 UNDERTAKER: Chas E. Evans & Son — ADDRESS: 1805 N Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48623

31 ✓ E 48623

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 N. Bond ST. 8-13 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert E. Lant

(a) RESIDENCE NO. 1235 N. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert E. Lant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Ann Schepeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Lillie M. Lee

(Address) 1235 N. Bond St.

15 Filed AUG 20 1929 C. HAMPSON JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19-1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 2 —, 1929, to Aug. 19 —, 1929, that I last saw h[illegible] alive on Aug. 7 —, 1929 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Microscopic

(Signed) Edwin B. Fenby M. D.

8/20/1929 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 8/22 1929

20 UNDERTAKER Chas. R. Maus & Son

ADDRESS 1180 N. Royal ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48624

CERTIFICATE OF DEATH

100-001

E 48624

1—PLACE OF DEATH

near Camp Holabird

REGISTERED NO.

CITY OF BALTIMORE: (No. 6111 Danville Ave. ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles D. Hamrick

(a) RESIDENCE NO. 6111 Danville Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. . How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 26/29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
-----	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Noah P. Hamrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Addie E. Ridgley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Noah P. Hamrick
(Address) 6111 Danville Ave.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19/1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14. 1929 19 ..... to Aug 19. 19 29.

that I last saw him alive on Aug 19. 19 29

and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Tetany, marasmus, ulcerative stomatitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin data

(Signed) Leo Schlamp, M. D.

, 19 (Address) 3024 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Aug 21/29
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48625

90 E 48625

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 33rd & Calvert ST. 7249 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Lillian Craigen Adams

(a) RESIDENCE NO. 3333 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Hanley Adams

6 DATE OF BIRTH (month, day, and year) Aug. 20, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 97

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER William Craigen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER Rebecca Pue

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Union Memorial Hospital
(Address) Baltimore

15 Filed ..... 19 ..... Registrar.

C. HAMPSON JONES M. D.

C 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1929

17 I HEREBY CERTIFY, That I attended deceased from August 18, 1929, to August 20, 1929, that I last saw her alive on August 19, 1929 and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis with
Arteriosclerosis
Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Palmer F. C. Williams, M. D.

8/20, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Aug 22nd 1929
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Sons Co	Oakland Baltimore Md

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48626

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48626

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of Baltimore: In Automobile Liberty Heights Ave & Belvedere Ave (Ward) 64

2-FULL NAME Emma J. Ecker

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 3715 Woodbine Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem'l	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 31 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
69	70	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co
(State or country) md.

PARENTS

10 NAME OF FATHER Edw. Null

11 BIRTHPLACE OF FATHER (city or town) Fredrich Co.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Swadon

13 BIRTHPLACE OF MOTHER (city or town) Fredrick Co
(State or country)

14 Informant Irene Ecker
(Address) 3715 Woodbine Ave

15 Filed ....., 19.... J. HAMPSON JONES, M. D. Registrar
AUG 20 1929
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular Attendant

(Signed) Hugo Muth, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beaver Dam Fredk. Co. md.	Aug 21 1929

20 UNDERTAKER Harry N. Ammarell ADDRESS 4224 Ridgewood Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

E 48627

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 4516 Penhurst Ave ST. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Gordon Roesch

(Residence in Baltimore: No. 4516 Penhurst Ave St.; 7 yrs., 9 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH. October (Month) 21 (Day), 1921 (Year)

7-AGE. 7 yrs. 9 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Emil A. Roesch

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Mae E Tucker

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emil A. Roesch

(Address) 4516 Penhurst Ave

15-

Filed....., 191.... C. HAMPSON JONES, M. D. Registrar.

SEP 26 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. 8 (Month) 19 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6th 1929, to Aug 19th 1929, that I saw h im alive on Aug 19th 1929, and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Pericarditis

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Arthritis

(Duration) yrs. mos. 15 ds.

(Signed) [signature] M. D.

8/19/29, 191... (Address) 736 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Woodlawn Cemetery

DATE OF BURIAL. Aug. 21, 1929.

20-UNDERTAKER Harry H Amacker

ADDRESS 4204 Hedgewood Av

CAUSE OF DEATH in plain terms, so that it may be of property claimed. Each statement of fact is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 48628

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 501 S Belnord ave 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Szambrotski

(a) RESIDENCE NO. 501 S Belnord ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particuiar kind of work

(b) General nature of industry, business, or estsblishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Konstanty Szambrotski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Zmudzejewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Konstanty Szambrotski
(Address) 501 S Belnord ave

15 Filed ... 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-17-1929

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to Aug 16. 1929, that I last saw him alive on Aug 16 1929 and that death occurred, on the date stated above, at 930 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Laryngeal T B C.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Laboratory X-Ray

(Signed) Nathan Gelfoot M. D.

(Address) 1818 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Aug	23 1929
20 UNDERTAKER	ADDRESS
John M Weber	401 S Chester

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48629

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48629

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St. 16-37 Ward)

2-FULL NAME William H Steele

(a) RESIDENCE NO. Summit Ave & Phila Rd St. Ward Parkville Balto Co. Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-13-1910

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	19	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Eastern Rolling Mill
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Jno Steele

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Laura Slater

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant John Steele
(Address) Phila Rd-Parkville

15 Filed AUG 20 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract. Skull. Comp. Communited while driving auto & trying round one ahead collided with another coming in opposite direction (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Concussion Chest

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? North Pt Rd nr Phila Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) P. J. Frame M. D.

8/19 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	8/21/29
20 UNDERTAKER George J Ruth	ADDRESS 1135 Hanover

tion should be carefully supplied. AGE should be stated EXACTLY. THIS BLANK MUST BE FILLED OUT. OCCUPATION OF DECEASED. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 48630

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1708 E. Federal ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Baldwin

(a) RESIDENCE NO. 1708 E. Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Baldwin

6 DATE OF BIRTH (month, day, and year) 11/11 1842

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
86	9	10 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework for

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ed Baldwin

(Address) 1708 E. Federal St

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to Aug 19, 1929,

that I last saw her alive on Aug 19, 1929

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T. Avery, M. D.

19 (Address) 1603 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakdawn Cem	8/21 1929
20 UNDERTAKER George J. Ruthgeb	ADDRESS 735 Harford Avenue

important. See instructions on back of certificates.

AUG 20 1929 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48631

CERTIFICATE OF DEATH

48631

E 48631

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland General ST. WARD)

2—FULL NAME Miss Violet Turfle

(a) RESIDENCE NO. Westminster, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) maryland

PARENTS

10 NAME OF FATHER Joseph Turfle

11 BIRTHPLACE OF FATHER (city or town) Carrol Co. (State or country) maryland

12 MAIDEN NAME OF MOTHER Liza Small

13 BIRTHPLACE OF MOTHER (city or town) Washington Co (State or country) maryland

14 Informant Hospital Record
(Address)

15 Filed AUG 21 1929 CAMPBELL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20-29.

17 I HEREBY CERTIFY, That I attended deceased from 8-13, 1929, to 8-20, 1929, that I last saw h.e. alive on 8-20-29, 19, and that death occurred, on the date stated above, at 7.20 p. m.

The CAUSE OF DEATH* was as follows:

Operated on for Hyperplastic Uterine mucosa
Chronic appendix
supravaginal hysterectomy appendectomy (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) 3 yrs. mos. 20 min ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8-14-29

Was there an autopsy? None

What test confirmed diagnosis? Clinical

(Signed) Joseph Turfle, M. D.

(Address) Westminster Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	Aug 23 1929
20 UNDERTAKER	ADDRESS
J. Francis Case	Westminster Md

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48632

CERTIFICATE OF DEATH.

113 E 48632

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH University Hospital Lombard & Green 2-4

City of BALTIMORE: (No. ... Ward)

2-FULL NAME Raymond Wemer

(a) RESIDENCE NO. 26 South Wolfe St ~~Rf.~~ Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 31/29

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Werner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Marie Hess

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Joseph Werner

(Address) 26 Wolfe St

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.)

and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Gastro-enteritis

(duration) ... yrs. ... mos. 5 ds.

(Signed) Alfred G. Gladis M. D.

(Coroner)

(Address) 1437 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs.. ... mos.. ... ds. In the State ... yrs.. ... mos.. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rood Cem Date of Burial June 21 1929

20 UNDERTAKER Chas Boucher ADDRESS 1400 Eutaw

very important. See instructions on back of certificate.

21 1929 G. HAWKINS, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48633

CERTIFICATE OF DEATH

E 48633

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Johns Hopkins Hosp (St.) (Ward)

2-FULL NAME Baby Finkel

(a) RESIDENCE NO. 1905 N Patterson Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 19/29

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Bab
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Henkel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Julia Loebler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Jacob Henkel
(Address) 1905 Patterson Park Av

15 Filed ..... 19 ..... CHARLTON JONES, M. D. Registrar

AUG 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary atelectasis Fetal

(duration) 1 yrs. — mos. — da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hospital History

(Signed) H. C. Jones, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Aug 21 19 29
20 UNDERTAKER Grant Grant & Son 1406 Eutaw	ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48634

100-001

E 48634

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 2237

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Burckheimer

(a) RESIDENCE NO. 1618 Oline ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) Sept. 26/29.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child ppd.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Henry Burckheimer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Marie Rittas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Hospital Records.

(Address)

15 Filed OCT 2 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20 29.

17 I HEREBY CERTIFY, That I attended deceased from 8-16, 19 29, to 8-20, 19 29,

that I last saw her alive on 8-20, 19 29,

and that death occurred, on the date stated above, at 10 22 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Marasmus

Not determined (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? X Ray.

(Signed) Edwin F. E. Williams, M. D.

8/29. 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Aug 22 1929
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	2072 Pres.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT---CITY OF BALTIMORE

E 48635

CERTIFICATE OF DEATH

161-001

E 48635

1-PLACE OF DEATH

City of Baltimore: (No. 1823 E Balto St. 2-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Berkowitz

(a) RESIDENCE NO. 1823 E Balto St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 25

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
		8	2

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Sinder Berkowitz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Silver

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto City

14 Informant Julia Silver
(Address) 1823 E Balto

15 Filed ... 19... HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) about 1 day yrs. mos. days.

CONTRIBUTORY (Secondary) undetermined

from no history - stillborn

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 1823 E Balto

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James H Watkins, M. D.

8 20 1925 (Address) 1823 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Woods Road	8-21-1925
20 UNDERTAKER	ADDRESS
Jack Levin	1424 E Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

43

E 48636

CERTIFICATE OF DEATH

REGISTERED NO. **E 48636**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest E. Price

(a) RESIDENCE NO. 1226 N Calvert St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Price Wife

6 DATE OF BIRTH (month, day, and year) July 16 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt, Md.

PARENTS

10 NAME OF FATHER Eli Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura McElfred

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Marie Price
(Address) 1226 N. Calvert St

15 Filed AUG 21 1929, 19 J. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1929, to Aug. 19, 1929, that I last saw him alive on Aug. 19, 1929 and that death occurred, on the date stated above, at 2:00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, General Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of May 27 1929

Was there an autopsy? no

What test confirmed diagnosis? Biopsy

(Signed) Jesse L. Fuller, M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 21 1929
20 UNDERTAKER Bide Winfield	ADDRESS Fremont Ave

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48637

CERTIFICATE OF DEATH

1279

E 48637

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2027 Druid Hill St. 14 Ward)

2-FULL NAME Katie Butler.

(a) RESIDENCE NO. 2027 Druid Hill St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) A A Co
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Butler

11 BIRTHPLACE OF FATHER (city or town) A A Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) A A Co
(State or country) Md

14 Informant Inez Burrough
(Address) 2324 Druid Hill Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) August 19th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) J. C. Guirk M. D.

Aug 20 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cem	Aug 21 29
20 UNDERTAKER Samuel Hensley	ADDRESS 1 Bridge

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48638 ✓ 129 E 48638

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 732 Dolphin ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Ellis

(a) RESIDENCE NO. 732 Dolphin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos H Ellis

6 DATE OF BIRTH (month, day, and year): Dec 29 1857

7 AGE: Years 72 | Months 7 | Days 19 | If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): no

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Chas Fowler.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Sarah Payne

(Address) 732 Dolphin St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929 to Aug 18, 1929

that I last saw her alive on Aug 18, 1929

and that death occurred, on the date stated above, at 9.40 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis + nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	Aug 21 1929
20 UNDERTAKER	ADDRESS
Samuel Wensley	728 N Gilmor

important. See instructions on back of certificates.

HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

48639

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH

REGISTERED NO. E 48639

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 Somerset Rd ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Francis Harper

(a) RESIDENCE NO. 501 Somerset Rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 7 mos. 20 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Kent, Widow

6 DATE OF BIRTH (month, day, and year) Oct 10, 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	7 10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Investment Banker 045

(b) General nature of industry, business, or establishment in which employed (or employer) Bond Underwriter Broker

(c) Name of employer Colonial Mtg Inv. Co.

9 BIRTHPLACE (city or town) Chagrin Falls O.
(State or country)

PARENTS

10 NAME OF FATHER Hector Harper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Shannon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant F. Harper

(Address) 501 Somerset Rd

15 Filed ..... 19 ..... Registrar

AUG 24 1929 H. LEXINGTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14 19 29 to Aug. 20 19 29

that I last saw him alive on Aug 20 19 29

and that death occurred, on the date stated above, at 2-20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Right Hemiplegia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis

(duration) 4+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) M. Gibson Porter, M. D.

8/20. 1929 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chagrin Falls Ohio	Aug 21 19 29
20 UNDERTAKER Henry H. Jenkins & Son 60	ADDRESS McCulloh & Orchard Sts

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

228180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 48640

E 48640

CERTIFICATE OF DEATH

129

REGISTERED NO. E 48640

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 713 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Levy

(a) RESIDENCE NO. 837 N. Washington St WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie

6 DATE OF BIRTH (month, day, and year) 12/19/57

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57 5-2	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Marie Weigert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed Aug 20, 1929 S. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 - 29

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to Aug 19, 1929.

that I last saw him alive on Aug 19, 1929

and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis. Hypertension -
Cerebral Hemorrhage left.
Hemiplegia rt -

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage - (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Sidney A Gladstone, M. D.

8/19, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Aug 22 1929
20 UNDERTAKER George W. Zickler	ADDRESS 1737 E. Eager St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48641 31 ✓ E 48641

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 428 S. Conwell ST. 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah J. Furlong

(a) RESIDENCE NO. 428 S. Conwell ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roland Furlong

6 DATE OF BIRTH (month, day, and year) Jan. 9-1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John T. Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah J. Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Roland Furlong

(Address) 428 S. Conwell St.

15 Filed ....., 19.... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20-1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Aug 20, 1929, that I last saw her alive on Aug 19, 1929, and that death occurred, on the date stated above, at 1.05 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation & Test

(Signed) Horace B. Fillow M. D.

8/20, 1929 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Aug 22 1929
20 UNDERTAKER George N. Zibler	ADDRESS 1737 E. Eager St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48642

CERTIFICATE OF DEATH

X 29 ✓

E 48642

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 76-37

CITY OF BALTIMORE: (No. Street ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Phelps

(a) RESIDENCE NO. 308 W 29th St, Wilmington, Del. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. 4 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	44	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter. 050

(b) General nature of Industry, business, or establishment in which employed (or employer) House painting.

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert E. Phelps.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Susan M. Hild

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Records
(Address) Baltimore City Hospitals.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20, 1929.

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929 to Aug 20, 1929.

that I last saw him alive on Aug 20, 1929.

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute with
Myocardial insufficiency.

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Nephritis, Chronic, with Edema

(duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Microscopic Exam.

(Signed) Theron C. McLean, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 23 1929
20 UNDERTAKER Wm J. Tucker Sons	ADDRESS Norfolk Va

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48643

CERTIFICATE OF DEATH.

185 ✓

15-62

REGISTERED NO. L 2563

1-PLACE OF DEATH 3405 Grantley Road

CITY OF BALTIMORE: (No. 3405 ST. Grantley Road WARD 15-62)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Summerfield Philander Walker.

(a) RESIDENCE. No. 3405 Grantley Road. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of.
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Stieff Piano Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John D. Walker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sarah Ann Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Nannie Walker
(Address) 3405 Grantley Road.

15 Filed , 19 Registrar

AUG 21 1929 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1 1929. to Aug 20 1929.
that I last saw h alive on Aug 20 1929.
and that death occurred, on the date stated above, at 8:25 A m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
Arteriosclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture Rt Hip

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exams

Signed Charles L Wright M. D.

19 (Address) 342 Egerton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 22 1929
20 UNDERTAKER	ADDRESS
Wm J Ficken & Sons	N. Pa

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of duration of each disease is required. Contributory causes may be stated on back of certificates.
TION is very important. See instructions on back.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74001

E 48644 — **CERTIFICATE OF DEATH** — **E 48644**

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 112 W. Monroe ST. 11-27 WARD)

2—FULL NAME Lucy Irene Wright

(a) RESIDENCE NO. 112 W. Monroe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Rev. Robt. L. Wright

6 DATE OF BIRTH (month, day, and year) Aug 8 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House 37

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Los Angeles, California

PARENTS

10 NAME OF FATHER: John Baldy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Illinois

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Rev Robt L Wright
(Address) 112 W Monroe

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20-1929

17 I HEREBY CERTIFY, That I attended deceased from Apr, 1925, to Aug 20, 1929

that I last saw her alive on Aug 19, 1929

and that death occurred, on the date stated above, at 4 15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy,

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Hypertension & Arteriosclerosis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) M B Cumberstock, M. D.

8/21, 1929 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug 23 1929
UNDERTAKER	ADDRESS
H. Sacks & Son	Northern

Important. See instructions on back of certificate.

AUG 21 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48645

CERTIFICATE OF DEATH. 1 84

E 48645

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4242 Park Heights Ave St., 5 58 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Harris

(a) RESIDENCE NO. Vineland, New Jersey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
Colored 72		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Camden, N. Jersey (State or country)

PARENTS

10 NAME OF FATHER [illegible] Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary McPherson

13 BIRTHPLACE OF MOTHER (city or town) New Jersey (State or country)

14 Informant Mrs. Mae Murphy (niece) (Address) 4242 Park Hts. Ave.

15 Filed AUG 21 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20-1929

17 I HEREBY CERTIFY, That I attended deceased from 8-13-1929, to 8-20-1929.

that I last saw h[illegible] alive on 8-20-1929.

and that death occurred, on the date stated above, at 1.20 A.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
cardiac dilatation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Traveled from New Jersey to Maryland, exacerbated the disease.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home. Vineland, N. J.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) Samuel A Gluck M.D.

, 19 (Address) 3914 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden N. J. DATE OF BURIAL Aug 21 1929

20 UNDERTAKER Wm J Tickner & Sons ADDRESS Norfolk

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

E 48646

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-002

E 48646

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 N. Washington ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Douglas T. Holden Jr.

(a) RESIDENCE NO. 1114 N. Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 18, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Douglas Holden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Douglas Holden

(Address) 1114 N. Washington St

15 Filed Aug 21 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from August 18th, 19 29, to August 20th 19 29,

that I last saw her alive on August 19th, 19 29

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(duration) 2 yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. 3 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. W. L. Howe, M. D.

(Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 22, 29
20 UNDERTAKER	ADDRESS
William G. Schaeffer	1816 Eutaw Pl

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 48647 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48647

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE; No. 1021 Hanover St. 23-31 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Schmidt

(a) RESIDENCE. No. 1021 Hanover ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick L Schmidt

6 DATE OF BIRTH (month, day, and year): Nov 25th 1840

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
88	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Philip King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Hatzicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Margaret A. Armandt

(Address): 1021 Hanover st.

15 Filed AUG 21 1929, 19 C. HAMPSON JONES, M. D. Registrar.

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to August 19, 1929, that I last saw h alive on Aug 19, 1929 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

from history (duration) Ans yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G H Armans, M. D.

Aug 19 1929 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Augst 22 1929
20 UNDERTAKER	ADDRESS
C Schloman & Son	1039 Hanover st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-12.23—M&T—500 Bks.

E 48648 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48648

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary S. [illegible] WARD)

REGISTERED NO. 46-429

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schmidt

(a) RESIDENCE NO. 4301 Wiltshire Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Sophia W. Schmidt

6 DATE OF BIRTH (month, day, and year): Oct 13th 1865

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
63	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Black Smith

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Frederick Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germ.

12 MAIDEN NAME OF MOTHER: Margaret Berg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ditto.

14 Informant: Margaret G. Armandt

(Address) 1021 Hanover St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-20 1929

17

I HEREBY CERTIFY, That I attended deceased from 8-15 1929, to 8-20 1929,

that I last saw him alive on 8-20- 1929,

and that death occurred, on the date stated above, at 2:55 p. m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Arteriosclerosis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Vernon H. Norwood M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem.

DATE OF BURIAL: Aug 22 1929

20 UNDERTAKER: E. Schloman & Son

ADDRESS 1039 Hanover St

AUG 21 1929

C. HAMPSON JONES, M. D.

Registrar

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48649

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 48649

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie B. Williams

(a) RESIDENCE NO. 618 Dolphin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married.

5a If married, widowed, or divorced (or) WIFE of Paul Williams.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launders

(b) General nature of industry, business, or establishment in which employed (or employer) Private homes.

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Edward Palm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Phebe Lamar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Records
(Address) Baltimore City Hospitals

15 Filed ..... 19 C. HAMPSON JONES, M. D.
2813 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1928, to August 18, 1929, that I last saw h[illegible] alive on August 18, 1929 and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into cerebrum, d.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General exam & lab.

(Signed) Marvin M. Wilson, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
ERSITY OF MARYLAND	Aug 21 1929
20 UNDERTAKER	ADDRESS
Commissioner of Health.	

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 48650

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Elliott ST. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Jasinski

(a) RESIDENCE NO. 3210 Elliott ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 9 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 26 1909

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Andrew Jasinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Smulski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Andrew Jasinski

(Address) 3210 Elliott St

15 Filed 2 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 17, 19 29, to Aug. 20, 19 29, that I last saw him alive on Aug. 19, 19 29 and that death occurred, on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.

8-21-29 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Aug 24 19 29
20 UNDERTAKER	ADDRESS
Wm Fialkowski	1020 S Kenwood Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48651

CERTIFICATE OF DEATH

1851 E 48651

1-PLACE OF DEATH

City of Baltimore: (No. 722 S. Conkling St., 26-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ernest Sr

(a) RESIDENCE NO. 722 S Conkling St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline

6 DATE OF BIRTH (month, day, and year) Jan 18 1849

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	80	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER
not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Charles Ernest Sr
(Address) 722 S Conkling St

15 Filed ..... 191.. C. HAMPSON JONES, M. D. Registrar

AUG 21 1929 By ECKS

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of femur
Fall down Stairs

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death? 722 Conkling

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fowler M. D.

8 29 1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Aug 23 1929
20 UNDERTAKER George W Zirkin	ADDRESS 1737 E Eager

IMPORTANT—Should be carefully supplied. Any error in this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—10J Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48652

CERTIFICATE OF DEATH

90 E 48652

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Front of 318 N. Mulberry 6 1 Ward)

2-FULL NAME ANDREW SKARDA

(a) RESIDENCE NO. 802 S. Clinton St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6 DATE OF BIRTH (month, day, and year): February 6,1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: M. V. Smith

9 BIRTHPLACE (city or town)
(State or country): Austria

PARENTS

10 NAME OF FATHER: Frank Skarda

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Austria

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Not Known

14 Informant (Address): Mrs. Wm. H. Lawson (Niece) 802 S. Clinton St.

15 Filed AUG 21 1929 19 C. HAMPSON JONES, M. D. Registrar

Bur 8813

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What abnormal conditions confirmed diagnosis? Pts History

(Signed) Wm. H. Lawson, M. D.

19 (Address) 443 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer Cemetery	Aug. 22, 1929
20 UNDERTAKER: Henry Sander & Sons Inc	ADDRESS: BALTIMORE ST. & BROADWAY

...ay be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 48653

1—PLACE OF DEATH

REGISTERED NO. 14-20

CITY OF BALTIMORE: (No. 1405 Druid Hill St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary Catherine Hughes

(a) RESIDENCE NO. 1405 Druid Hill ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Hughes

6 DATE OF BIRTH (month, day, and year) Jan. 13 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mary Hooker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Walter E. Hughes

(Address) 1405 Druid Hill

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 27th, 19 29, to Aug 14th, 19 29, that I last saw h alive on Aug. 14th, 19 29 and that death occurred, on the date stated above, at 1145P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Asa Eichelberger, M. D.

19 (Address) 1913 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 8/22 1929

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1413 Druid Hill Ave.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48654

CERTIFICATE OF DEATH

90 E 48654

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1-13 Laurel St., Fremont Ward)

2-FULL NAME Walter Williams

(a) RESIDENCE NO. 1729 Madison St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) [redacted] 1893

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) O/o
(c) Name of employer

9 BIRTHPLACE (city or town) S. C.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Mary J. Oliver

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Wm. Williams Jr.
(Address) 611 Dolphin St.

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Contributory Exhaustion

DURATION: (duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

DURATION: (duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	8/22 1929
20 UNDERTAKER Mrs. Geo H. Holland	ADDRESS 1631 Bond St

HAMPSON JONES

2 1929

IMPORTANT: THIS CERTIFICATE should be carefully supplied. ALL items should be stated EXACTLY. THIS CERTIFICATE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48655

CERTIFICATE OF DEATH.

X 11-1002

E 48655

1-PLACE OF DEATH U. S. Marine Hospital 12-51

City of BALTIMORE: (No. _____ St. _____ Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raimundo Cruz

(a) RESIDENCE NO Puerta De Tierra St. _____ Ward _____ Porto Rico

(Usual place of abode)

Length of residence in city or town where death occurred yrs. _____ mos. _____ ds. 1 (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. 11 mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer U. S. Navy Yard

9 BIRTHPLACE (city or town) _____

(State or country) Porto Rico

PARENTS

10 NAME OF FATHER R. Cruz

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Porto Rico

12 MAIDEN NAME OF MOTHER Alicia Corchado

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Porto Rico

14 Informant U. S. Marine Hospital

(Address) Locust Point

15 Filed _____, 19 _____ Registrar

J. HAMPSON JONES, M. D.

AUG 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) J-28 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Generalized Tuberculosis

Ulcer

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

(Coroner)

(Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery Date of Burial Aug. 22, 1929

20 UNDERTAKER E. Leroy Stiffler, Inc. ADDRESS 1256 North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 48656

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

179 E 48656

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp St. 1-3 Ward)

2-FULL NAME Frank Olszewski

(a) RESIDENCE NO. 915 S. Belnord Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 22 1926

7 AGE Years	Months	Days 29	IF LESS than 1 day.....hrs. or.....min.
2	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Peter Olszewski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Elizabeth Cholewinski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) germany

14 Informant Elizabeth Olszewski

(Address) 915 S. Belnord ave

15 Filed ....., 19.....

HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc Burns

Having arms Coal oil Stove

Burns 1-2 ms Body

CONTRIBUTORY (Duration) yrs. mos. 1 ds.

Aug 21/29 Shock

(Signed) J C Hicks (Coroner) M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St. Stanislaus Cem Aug 22 1929

20 UNDERTAKER

Stephen J. Fialkowski Inc

ADDRESS 1010 S Kenwood Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 21 1929

Spec.—2-29-28—L. F. S.—500 Bks.

(Sieber)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48657 | CERTIFICATE OF DEATH | 148 E 48657

1—PLACE OF DEATH St Joseph Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Cumberland ST. 5-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Silber

(a) RESIDENCE NO. 3528 College ST. 2nd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick C Sieber

6 DATE OF BIRTH (month, day, and year) Dec 20, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Lonaconing Md

PARENTS

10 NAME OF FATHER Geo. W. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna B Ridgley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. W. Lewis

(Address) 3528 Cottage Ave

15 Filed AUG 21 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/21/29

17 I HEREBY CERTIFY, That I attended deceased from 8-26-29, 19..., to 8-21-29, 19...

that I last saw h alive on 8-21-29, 19...

and that death occurred, on the date stated above, at 7 P.M. m.

The CAUSE OF DEATH* was as follows: Nephritis Interstitial Pregnancy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. Sudden

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical Cause

(Signed) N B Hundley, M. D.

(Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 8/24 1929

20 UNDERTAKER D. Gilmore Cook — ADDRESS 1217 E Baltimore St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48658

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48658

CERTIFICATE OF DEATH

113

1—PLACE OF DEATH

REGISTERED NO. 1-3

CITY OF BALTIMORE: (No. 510 S Port St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Borowicz

(a) RESIDENCE NO. 510 S Port St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Borowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agatha Borowicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Agatha Borowicz

(Address) 510 S Port St.

15 Filed 8 21 1929, 19 C. HAMPSON JONES, M. D. Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1929, to Aug. 21, 1929, that I last saw him alive on Aug 21, 1929, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Entero Colitis

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Andrew Borowicz, M. D.

8/31, 1929 (Address) 7579 Easton Rd,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Aug	23 1929
20 UNDERTAKER	ADDRESS
John M Weber	4012 Chester Ave

Spec.—2-29-28—L. F. S.—500 Bks.

(Bowen)

E 48659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 48659

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1802 n. Carey ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Arhilda Bowen

(a) RESIDENCE NO. 1802 n. Carey ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2. 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Arthur Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md ?

12 MAIDEN NAME OF MOTHER Laetta Fowler

13 BIRTHPLACE OF MOTHER (city or town) Prince George Co (State or country) Md.

14 Informant Mrs. Laetta Bowen (mother)

(Address) 1802 N. Carey

15 Filed AUG 21 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, '29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1929, to Aug. 19, 1929, that I last saw her alive on Aug. 19, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. 5 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. & am.

(Signed) W. T. Perry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 22 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 307 Preston St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48660

CERTIFICATE OF DEATH

X 100-001

E 48660

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 4-7 (WARD)

2—FULL NAME Mrs Margaret Mehl

(a) RESIDENCE NO. 105 E. Joppa Rd ST., WARD Balto Co Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Card

(Address)

15 Filed AUG 22 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/21/29

17 I HEREBY CERTIFY, That I attended deceased from 3/30, 19 29, to 8/21, 19 29, that I last saw h[illegible] alive on 8/21/29, 19 and that death ocrurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) auricular fibrillation, cardiac decompensation (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm N. McTaul Jr, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Maria Cemetry	Aug, 24 1929
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48661 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 48661**

CERTIFICATE OF DEATH + 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 447 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Simon J Cornish

(a) RESIDENCE NO. Taylors Island ST., Dorchester Co. Md. WARD M
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer None

(b) General nature of industry, business, or establishment in which employed (or employer) 200

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co Md.
(State or country)

PARENTS

10 NAME OF FATHER Harry Cornish

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Senator Ogden

(Address)

15 Filed 2 2 1929 C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20 1929

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1929, to August 20, 1929, that I last saw h[illegible] alive on August 20, 1929 and that death occurred, on the date stated above, at 7.40 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral accident

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio Sclerotic Cardio Vascular Renal Disease (duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Sascha F. Ginglia, M. D.

8/20, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	8-23 1929
20 UNDERTAKER	ADDRESS
Daniel Easton	Md

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks.

227979. E 48662 129 E 48662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 27-46

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George S. Spindler

(a) RESIDENCE NO. 5-205-York Rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth

6 DATE OF BIRTH (month, day, and year) 2/2/53

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Reeds — (Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

AUG 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21-29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1929, to Aug. 21, 1929, that I last saw him alive on Aug. 21, 1929, and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis complicated by hypertension and questionable chronic nephritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~complicated~~ extraction of teeth, O. D.

Did an operation precede death? Yes Date of Aug 13, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) A. H. Markham, M. D.

, 19 (Address) The J H Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Aug 24 1929
20 UNDERTAKER	ADDRESS
Jeriah Jeffries	1600 W North Ave

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Blks.

E 48663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1855

E 48663
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pete Panamarow

(a) RESIDENCE NO. 359 S. Caroline Street St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Panamarow

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pool Room Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Stephen Panamarow

11 BIRTHPLACE OF FATHER (city or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Julia Panamarow

(Address) 359 S. Caroline Street

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

ACC Fall

Fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Scotts Run Cem. Co. Aug. 23 1929

Russian Independent

20 UNDERTAKER ADDRESS

George A. Weber 705 S. ...

N. B.—Write plainly in ink. Fill in all blanks. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 22 1929 HAMPSON JONES M. D.

AUG 23 1929

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 48664

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48664

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 S. Ellwood ave ST.: 1-K WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander J. Cochran

(a) RESIDENCE. No. 115 S. Ellwood ave ST.. ..... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret B. Cochran

6 DATE OF BIRTH (month, day, and year) Mar 9-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	10.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipfitters

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer Balto. Dry docks

9 BIRTHPLACE (city or town) (State or country) Eng.

PARENTS

10 NAME OF FATHER Robt. Cochran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eng.

14 Informant Margt. B. Cochran
(Address) 115 S. Ellwood ave

15 Filed AUG 22 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1928, to Aug 19, 1929, that I last saw him alive on Aug 17, 1929, and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Unresolved Pneumonia
Chronic Arthritis

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Myocard. Insufficiency Pulmonary Edema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. G. Leyh M. D.

, 19 (Address) 1561 Mt. Vernon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	8/22 1929
20 UNDERTAKER J. A. Moran	ADDRESS 2941 E. Baltimore

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact duration of disease is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Mary a Rafferty

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48665

E 48665

CERTIFICATE OF DEATH

91-002

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 149 N Curley St., 6-11 (Ward)

2-FULL NAME Mary A. Rafferty

(a) RESIDENCE NO. 149 N Curley St., 9 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Rafferty

6 DATE OF BIRTH (month, day, and year) Jan 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James Boyle

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant James [redacted] Rafferty Jr
(Address) 149 N. Curley St. Jr

15 Filed ..... 19 ..... G. HAMILTON JONES, M. D. Registrar

G 24933

G 24923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Duration: (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Duration: (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. C. Hadley, M. D.

19 (Address) 103 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 24 1929
20 UNDERTAKER John A. Moran	ADDRESS 3009 E Balto St.

tion should be carefully supplied. Any erasure, alteration or illegible entry may be detected. CAUSE OF DEATH should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 48666

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48666

CERTIFICATE OF DEATH.

129

Registered No. 16-76

1-PLACE OF DEATH

City of BALTIMORE: (No. 1604 Arlington ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Miss Flannie Lannan.

(a) Residence No. 604 Arlington Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 4-1900

7-AGE. 28 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Butte Mt.

PARENTS.

10-NAME OF FATHER, Edward P. Lannon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Rose Bradley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) Edw F. Lannon

(Address) 604 Arlington ave

15- Filed ..... 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 21 1929

17- I HEREBY CERTIFY, That I attended deceased from February 27 19 29 to August 21 19 29

that I last saw h... alive on August 21 19 29

and that death occurred, on the date stated above, at 3-15 p. m.

The CAUSE OF DEATH was as follows: Acute Cardiac Dilatation

(Duration) 6 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Edw. F. Lannon

(Signed) 4704 York Road, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem. DATE OF BURIAL. aug 24. 1929

20-UNDERTAKER. J. J. Moran ADDRESS 3000 E Baltimore

In preparing, see instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 48667 HEALTH DEPARTMENT—CITY OF BALTIMORE D 48667

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital 129

REGISTERED NO.

CITY OF BALTIMORE: (No. Monument St. 10-14 STREET WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Mellman

(a) RESIDENCE NO. 1120 East Monument ST., — WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? 45 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX [redacted]

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) ~~Married~~ Remarried. 17

5a If married, widowed, or divorced (or) WIFE of G. Mellman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65 years.	Birthday unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 27

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Betzen Rothlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria.

12 MAIDEN NAME OF MOTHER Rebecca —?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Hosp. Record (Address)

15 Filed AUG 22 1929, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/21 1929

I HEREBY CERTIFY, That I attended deceased from 8/13, 1929, to 8/21, 1929.

that I last saw her alive on on 8/21, 1929

and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation,
arteriosclerosis
chronic nephritis.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) uremia.

8/13/29 (duration) — yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) [illegible], M. D.

8/21, 19 29 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fitzhugh Herring Run — DATE OF BURIAL 8-22-1929

20 UNDERTAKER Jacob Lewis, 1439 E. Balto. — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 48668 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 **E 48668**

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1328 E. Hoffman St., 8016 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Clancy

(a) Residence No. 1328 E. Hoffman St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Clancy.

6-DATE OF BIRTH (month, day and year) May 1843

7-AGE. 86 yrs. 3 mos. ds.

If LESS than 1 day. hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. James O'Malley

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Ireland

14- (Informant) Ed. Clancy

(Address) 2328 E. Hoffman St.

15- Filed ..... 192 C. H. JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 20. 1929

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1929 to Aug 20 1929.

That I last saw h[illegible] alive on Aug 19 1929.

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. C. Herzog M. D.

8/20, 1929 (Address) 1305 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral

DATE OF BURIAL. 8/23/29

20-UNDERTAKER. George J. Rutz & Son

ADDRESS 123 Hanford

instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48669 (2 21)

CERTIFICATE OF DEATH

E 48669

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Timmerman

(a) RESIDENCE NO. 2018 E - Hoffman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/14/1928

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	1	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Timmerman

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Plitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 8/27 19 29 C. HARRISON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20/29

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1929, to August 20, 1929, that I last saw h[illegible] alive on August 20, 1929 and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

1. Pertussis

(duration) yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) Gastro intest. Not Syphilitic

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Benj. E. Hodge, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	8/31/29
20 UNDERTAKER	ADDRESS
Geo. P. Ruth & Son	1735 Harford Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48670

CERTIFICATE OF DEATH

E 48670

1—PLACE OF DEATH

REGISTERED NO. H-30

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert F. Scheff

(a) RESIDENCE NO. Halethorpe Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 1 mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche F. Scheff nee Linder

6 DATE OF BIRTH (month, day, and year) Jan. 9 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or... min.
	51	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Scheff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Blanche F. Scheff

(Address) Work Shop Halethorpe

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24 1929

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1929, to August 21, 1929, that I last saw him alive on August 21, 1929 and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the transverse colon

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of July 6 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Samuel J. Helms, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug. 23 / 19 29
20 UNDERTAKER Harry V. White, 1531 W Lombard St	ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Irma S. Stevens

E 48671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

147 E 48671

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 639 S. Pulaski St. ST. 16-27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irma S. Stevens

(a) RESIDENCE NO. 639 S. Pulaski St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Stevens

6 DATE OF BIRTH (month, day, and year) May 17 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles H. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Dora Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. Clarence E. Stevens

(Address) 639 S. Pulaski St.

15 Filed AUG 22 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1929, to Aug 21st, 1929, that I last saw h alive on Aug 21st, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Phlebitis Femoral Vein

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Ear Hamilton, M. D.

8/22, 19 (Address) 1211 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	8/24 1929

20 UNDERTAKER Harry K. Wiltshe ADDRESS 1531 W. Lombard st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48672

CERTIFICATE OF DEATH

38 ✓

E 48672

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 26-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Ruth

(a) RESIDENCE NO. 1605 S. East St. ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April the 6th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	- 4	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John F. Ruth

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Tudor

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Records
(Address) Baltimore City Hospitals.

15 Filed AUG 22 1929 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20th 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to August 20, 1929, that I last saw him alive on August 20, 1929, and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Syphilis Aorta with aneurysm.
Myocarditis, chronic.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Herman M. Thomas, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkswood Cemetery	Aug. 23rd 1929
20 UNDERTAKER	**ADDRESS**
Lilly & Gilmore	405 N. Mryland Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48673

CERTIFICATE OF DEATH.

1806002

E 43673

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq Hospital St. 427 Ward)

2-FULL NAME John Mc Leroy

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) In Quarries

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country) —

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —

(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) —

14 Informant .....

(Address)

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13- 1929

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acc. Blasting Stone

Fracture of Skull

(duration) yrs. mos. — ds.

CONTRIBUTORY (secondary) Shock

(duration) yrs. mos. ds.

(Signed) A C Finder M. D.

(Coroner)

18 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. Date of Burial AUG 22 1929

20 UNDERTAKER HARRISON JONES, M. E. ADDRESS Com. Bd. of Health

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Per Mr. E. Nogal.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48674 — **CERTIFICATE OF DEATH.** — 182 — **E 48674**

1-PLACE OF DEATH

City of BALTIMORE: (No. Fund Pier 3-Pratt St. St. 4-6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(a) RESIDENCE NO. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed, M. D.
(Coroner)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HAMPSON JONES, M. PUBLIC CEMETERY. AUG 22 1929

Commissioner of Health.

Spec.—2-29-28—L. F. S.—500 Bks.

Vol 2135-

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48675

CERTIFICATE OF DEATH

E 48675

1—PLACE OF DEATH CITY OF BALTIMORE: (No. Maryland Penitentiary ST., 10-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Oresten Marsh

(a) RESIDENCE NO. Westminster, Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 10 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah L. Marsh

6 DATE OF BIRTH (month, day, and year) Sept. ?, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	11	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kiod of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Louis Sterner

9 BIRTHPLACE (city or town) (State or country) Union Mills Md.

PARENTS

10 NAME OF FATHER Luther C. Marsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Gougher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll

14 Informant John Oresten Marsh

(Address) Md. Penitentiary

15 Filed AUG 22 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1929 to August 9, 1929 that I last saw him alive on August 9 1929 and that death occurred, on the date stated above, at 12-20 P. m.

The CAUSE OF DEATH* was as follows: Dislocation 5th Cervical Vertebras. (Hanged by Order of Court)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. W. M. Edmunds M. D.

, 19 (Address) Md. Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY	19

20 UNDERTAKER Commissioner of Health. ADDRESS AUG 22 1929

Important. See instructions on back of certificate.

Spec.—12-23-21—E.B.R.S.—400 Bks.

E 48676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48676

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 Shields Pl St., 17-24 38 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Rayner

(a) Residence No. 1113 Shields Pl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 19, 1929

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 11 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Newborn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md (State or Country),

PARENTS.

10-NAME OF FATHER Arthur Farrel Rayner

11-BIRTHPLACE OF FATHER (city or town) North Carolina (State or Country),

12-MAIDEN NAME OF MOTHER, Lillie Wilson

13-BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or Country),

14- (Informant)

(Address)

15- Filed AUG 22 1929, 192..., C. HAMILTON JONES, M. D. Registrar.

In plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 19 1929

17- I HEREBY CERTIFY, That I attended deceased from Aug 19, 1929 to Aug 19, 1929 that I last saw h~~im~~ alive on Aug 19, 1929 and that death occurred, on the date stated above, at 11.30P m

The CAUSE OF DEATH* was as follows:

Premature newborn -
(24 wks.)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Syphilis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirms diagnosis? Physical Signs

(Signed) ..... M. D.

8/21/29 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. LORRAINE CEMETERY.

DATE OF BURIAL. AUG 22 1929

20-UNDERTAKER. Per Wm. A. WOODALL.

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

Laymon.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 ✓ E 48677

E 48677

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Teresa Laymon

(a) RESIDENCE NO. 1821 E 11th Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Laymon

6 DATE OF BIRTH (month, day, and year) Dec 8, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Andrews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Accetta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rose Herrmann

(Address) 1508 Hamburg Ave

15 Filed AUG 24 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20/29

17 I HEREBY CERTIFY, That I attended deceased from 8/10/29, 19..., to 8/20/29, 19...,

that I last saw h[illegible] alive on 8/20/29, 19...

and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

carcinoma of uterus

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/15/29

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) M Hendrix M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Aug 24 1929

20 UNDERTAKER Frank A Pikitone

ADDRESS 2818 E Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48678

CERTIFICATE OF DEATH

1929

E 48678

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., Ward)

2-FULL NAME Edward Gibson

(a) RESIDENCE NO. 1601 E Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11, 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
28	27	11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) St Mary Co
(State or country) Md

PARENTS

10 NAME OF FATHER John H Gibson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Gussie Deminee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Clarence T. Gibson
(Address) 1222 N. Gilmor St

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held a Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:
Homicide Stab Wound
Knife to Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did An operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

(Signed) H. O. Gladis, M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 22, 1929
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	3221 Schroeder St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48679

CERTIFICATE OF DEATH

89

E 48679

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4209 Belvieu Ave. ST. 28-63 (AVE.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Lee Frankenfield,

(a) RESIDENCE NO. 4209 Belvieu Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaretta R. Frankenfield,

6 DATE OF BIRTH (month, day, and year) Nov. 9. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bond Salesman,

(b) General nature of industry, business, or establishment in which employed (or employer) Bond

(c) Name of employer

9 BIRTHPLACE (city or town) Cockeysville

(State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER John W. Frankenfield,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Richmond

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland.

14 Informant Mrs. Margaretta R. Frankenf

(Address) 4209 Belvieu Ave.

15 Filed AUG 22 1929 H. LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG 22 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-21, 1929, to 8-22, 1929, that I last saw him alive on 8-22, 1929 and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Acquired Pictures

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Garfield M. D.

8-22, 1929 (Address) 3402 Groveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Woodlawn — DATE OF BURIAL AUG 24 1929 19

20 UNDERTAKER Geo. W. Little — ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 48680

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH

E 48630

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 N.Fulton Ave. ST. 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna D.Paper,

(a) RESIDENCE NO. 1136 N.Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~, (write the word)
Female	White	Married

6 If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of George W.Paper.

6 DATE OF BIRTH (month, day, and year) April 2.1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Mark Harrison,

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Davis,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant George W.Paper,

(Address) 1136 N?Fulton Ave.

15 Filed AUG 22 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 21, 1929.

that I last saw h alive on Aug 21, 1929

and that death occurred, on the date stated above, at 11 a, m.

The CAUSE OF DEATH* was as follows:

Cerebral Hamorrhage

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) * yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr J Thom Talbot, M. D.

, 19 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park — DATE OF BURIAL 19

20 UNDERTAKER Geo W Little — ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 48681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1130

REGISTERED NO. E 48681

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Marshall St. 14-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte C. Eder

(a) RESIDENCE NO. 1707 Marshall ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 8, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: David J. Eder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: David J. Eder

(Address) 1707 Marshall St.

15 Filed AUG 22 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929 to Aug 21, 1929

that I last saw h alive on Aug 21, 1929

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. 11 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. L. Campbell M. D.

(Address) 1644 Hanover

Aug 22, 1929

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 23 1929
20 UNDERTAKER	ADDRESS
Howard E. Flynn	422 Light St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓

E 48682

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Riverside Ave St. W.H. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth M. Ruffini

(a) RESIDENCE NO. 1108 Riverside Ave

(Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Emil Ruffini

6 DATE OF BIRTH (month, day, and year): July 30, 1892

7 AGE — Years: 37 — Months: 0 — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm St. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Mary E. Schroeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Emil Ruffini

(Address): 1108 Riverside Ave

15 Filed ..... 19 ..... Registrar

AUG 22 1929 HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 20/29

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1928 to Aug 20, 1929

that I last saw h alive on Aug 20, 1929

and that death occurred, on the date stated above at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Adynamia (duration yrs. mos. ds.)

CONTRIBUTORY (Secondary) Malnutrition (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Chamberlain M. D.

Aug 21 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Aug 23, 1929
20 UNDERTAKER	ADDRESS
Margaret E. Flynn	1422 Bank St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48683

86-001

E 48683

CERTIFICATE OF DEATH

1—PLACE OF DEATH South. Balt., Gen. Hospital — REGISTERED NO. 43-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ____ ST. ____ WARD)

2—FULL NAME Mrs Thelma F. Gaunt

(a) RESIDENCE NO. 813 Union Ave ST. Hampden WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. 20 ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Gaunt

6 DATE OF BIRTH (month, day, and year) Aug. 1-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	24	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucille Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles H. Gaunt

(Address) 813 Union Ave.

15 Filed 2 2 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/21/29

17 I HEREBY CERTIFY, That I attended deceased from 8/20, 1929, to 8/21, 1929, that I last saw her alive on 8/21/29, 19 ____ and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Brain Abscess

(duration) ____ yrs. ____ mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis J. Tilden, M. D.

19 (Address) S. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Aug. 24 1929
20 UNDERTAKER	ADDRESS
Horace T. Bruce	3611 Falls Road

Important: See instructions on reverse side.

Spec.—2-29-28—L. F. S.—500 Blks.

2 2 E 408 48684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x155 E 48684

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernestine Rose

(a) RESIDENCE NO. Spamers Point Md ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	Infant -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mabel Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 22 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21-1929

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to Aug 21, 1929

that I last saw h.. alive on Aug 21, 1929

and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Purulent Meningitis

(duration) yrs. mos. 3 ds. ?

CONTRIBUTORY (Secondary) Otitis suppurativa Journ

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1929

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) G. B. Hunt M. D.

Aug 22, 1929 (Address) Johns Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Centery	Aug 23 1929

20 UNDERTAKER Ida L Snowden ADDRESS 1768 Madison, E

Important. See instructions on back of Certificate

Spec.—2-29-28—L. F. S.—500 Bks.

(Cattus)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48685

CERTIFICATE OF DEATH

140

E 48685

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St. 14-20 WARD)

2—FULL NAME Mrs Mercede Collins

(a) RESIDENCE NO. 140 / Eutaw Pl ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr. Collins

6 DATE OF BIRTH (month, day, and year) Aug 29. 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York City
(State or country)

PARENTS

10 NAME OF FATHER Wm. C. Rafferty.

11 BIRTHPLACE OF FATHER (city or town) New York.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Kilpatrick

13 BIRTHPLACE OF MOTHER (city or town) W. Y. C.
(State or country)

14 Informant Mercy Hospital
(Address)

15 FILED 2 2 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/27, 19 29, to 8/22, 19 29, that I last saw her alive on 8/22, 19 29, and that death occurred, on the date stated above, at 5:02 PM.

The CAUSE OF DEATH* was as follows:

Cardiac failure

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs 1 mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? yes. Date of July 5, 10, 1929

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm N. McFaul Jr, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	8/23/29
20 UNDERTAKER Joyce & Farley	ADDRESS Fayette

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~E 48586~~ E 48686

CERTIFICATE OF DEATH

139 E 48686

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1014 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Skinner

(a) RESIDENCE NO. 831 Ashland ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Skinner

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Geo. Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 2 1929 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Aug 19, 1929, that I last saw her alive on Aug. 19, 1929, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Uremia

Large myomatous uterus pressing on ureters

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) 18 yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood chemistry

(Signed) W. S. Everett, M. D.

Aug 20 1929 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	8-24 1929
20 UNDERTAKER	ADDRESS
Chas M. Skinner	1625 E. Mad st

Important: Use instructions on reverse side

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48687

CERTIFICATE OF DEATH

10-002

E 48687

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 25-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Betty G. Daniels

(a) RESIDENCE NO. 3705 S. Hanover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 20. 1926

7 AGE: Years 3 | Months 6 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James M. Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Ella M. Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: James M Daniels

(Address): 3705 S. Hanover St

15 Filed 2 2 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Aug 21, 1929, that I last saw her alive on Aug 21, 1929 and that death occurred, on the date stated above, at 4 05 p m.

The CAUSE OF DEATH* was as follows:

Nasal & Tonsillar Diphtheria

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Diph. Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

Aug 22 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug 23 1929

20 UNDERTAKER: A Howard Evans — ADDRESS: 38 E Fort Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48688

100-001

E 48688

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1337 Morling Ave ST., 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morgan W. Barrett Jr.

(a) RESIDENCE NO. 1337 Morling Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child.

6 DATE OF BIRTH (month, day, and year): April 15, 1929.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. (Dead)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Morgan W. Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Selma Cole.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Morgan W. Barrett.
(Address): 1337 Morling Ave.

15 Filed: AUG 22 1929 C. HAMPSON JONES, M. D. Registrar
By

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/19—, 1929, to 8/21—, 1929, that I last saw h— alive on 8/21, 1929, and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Bio Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. F. Campbell M. D.

8/22, 1929 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druton Balto Co.	Aug 23, 1929.
20 UNDERTAKER	ADDRESS
Chenoweth Son	3415 Chestnut Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48689 E 48689

CERTIFICATE OF DEATH

66

1—PLACE OF DEATH University Hospital REGISTERED NO. 27-56

CITY OF BALTIMORE: (No. ... S. ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME McKinley Englar

(a) RESIDENCE NO. 4001 Belvedere Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Effie Englar

6 DATE OF BIRTH (month, day, and year) Nov. 20. 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coppersmith

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer Union Shipbuilding Co

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Benjamin F Englar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C O Englar

(Address) 3121 Woodland Ave

15 Filed 8 22 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from August 16th, 1929, to August 20th, 1929, that I last saw him alive on August 20th, 1929, and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilirium Tremens

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Louis P. Jakobs, M. D.

Aug 29 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bridge Md

DATE OF BURIAL 8 23 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 48690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

148 E 48690

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Md General Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Melvin

(a) RESIDENCE NO. 1601 Druid Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Melvin

6 DATE OF BIRTH (month, day, and year) Jan 15/98

7 AGE Years 31 Months 7 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Hugh H. Eagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Caroline Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hospital Records
(Address)

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/22/29

17 I HEREBY CERTIFY, That I attended deceased from 8/20/29, 19 to 8/22/29, 19; that I last saw h[er] alive on 8/22/29, 19; and that death occurred, on the date stated above, at 5:50 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Acute Diffuse Nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia
(duration) yrs. mos. 18 hrs ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery DATE OF BURIAL Aug 24 1929

20 UNDERTAKER William Cook ADDRESS 1217 St Paul

AUG 22 1929

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Hamilton

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48691

CERTIFICATE OF DEATH

90

E 48691

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1003 Worden ST. 10-13 WARD)

2—FULL NAME Theresa Kelly

(a) RESIDENCE NO. 1003 Worden ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Kelly

6 DATE OF BIRTH (month, day, and year) Aug 26, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Tingan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Duff

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant James Kelly

(Address) 1003 Worden St

15 Filed ....., 19 .....

2 27 1929

HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1929 to Aug 22. 1929

that I last saw h alive on Aug 20, 1929

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1003 Worden

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Hamilton, M. D.

8 22 1929 (Address) 1002 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Ignatius, Harford Co Md	8/24 1929
20 UNDERTAKER	ADDRESS
J. M. Cook	1214 E Baltimore St

Important. See instructions on reverse side.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48692 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48692

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Greenway Apts. St. 12-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Lawton Norwood

(a) RESIDENCE NO. Greenway Apts, Charles St. circle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Morgan Norwood

6 DATE OF BIRTH (month, day, and year) Oct.6, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sec'ty Treas. of

(b) General nature of industry, business, or establishment in which employed (or employer) E. E. Jackson

(c) Name of employer Lumber Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas E. Norwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hyattsville, Md.

12 MAIDEN NAME OF MOTHER Eleanor Lawton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mary Morgan Norwood

(Address) Greenway Apts.

15 Filed 8 22 1929, 19 C. HAMPSON JONES, M. D. Per RKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-21, 1929

17 I HEREBY CERTIFY, That I attended deceased from July-24, 1929. to Aug 21, 1929. that I last saw h im alive on Aug-20, 1929 and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Chronic-Nephritis-
Arterio Sclerosis -

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia -

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Baltimore -

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Usual Laboratory Tests

(Signed) Joseph W. Kelly, M. D.

(Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Aug.23, 1929

20 UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw Place — ADDRESS

M O Mitchell

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48693

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 E Chase ST 11-15 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret J. Scott

(a) RESIDENCE NO. 11 E. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 2. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James. Scott.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Cindie atwell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Nora E Scott.

(Address) 2612 N. Charles St

15 Filed ..... 19 ..... Registrar.

G HAMPSON JONES M.D.

22 1929 RPW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1927, to Aug 21, 1929, that I last saw her alive on Aug. 20 1929, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Infectious Arthritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Bacteriological

(Signed) Harry R. Black Jr. M. D.

8-22 1929 (Address) 1100 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Aug 23 1929
20 UNDERTAKER John O Mitchell & Son	ADDRESS 1917 Eutaw Place

Important. See instructions on back of this sheet.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48694 — 129 ✓ — E 48694

CERTIFICATE OF DEATH

1—PLACE OF DEATH Home for Incurables — REGISTERED NO.

CITY OF BALTIMORE: (No. 40th St. or Cedar Ave., ST. 12-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa Rawlings King

(a) RESIDENCE NO. 2118 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If ~~married~~, widowed, or ~~divorced~~, ~~HUSBAND of~~ (or) WIFE of Alexander King-Deceased

6 DATE OF BIRTH (month, day, and year) Dec 2 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Moses Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca M Culloh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ada Rawlings Cresap

(Address) 621-S-33

15 Filed AUG 22 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22 '29

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to Aug 22, 1929,

that I last saw her alive on Aug. 22, 1929

and that death occurred, on the date stated above, at 2:25 pm.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocardial Insufficiency

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) W W S Mayo, M. D.

Aug 22, 1929 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland Md	Aug 23 1929

20 UNDERTAKER Dpm & Trademan for Mortuar — ADDRESS

Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 48695 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48695

CERTIFICATE OF DEATH.

8-17 13

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1514 E. Oliver St., E. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Marie Kerr

(a) Residence No. 1514 E. Oliver St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	W	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 28, 1928

7-AGE. 1 yrs. 10 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Balto. Md (State or Country),

PARENTS

10-NAME OF FATHER John L. Kerr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Katherine A. Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) John L. Kerr

(Address) 1514 E. Oliver

15- Filed AUG 22 1929 C. HAMPSON JONES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 21-29

17- I HEREBY CERTIFY, That I attended deceased from Aug 9- 1929 to Aug 21 1929

That I last saw her alive on Aug 21 1929

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Diarrhea & Enteritis.

(Duration) yrs. mos. 14 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) L. Pirosh M. D.

8-22-1929 (Address) 1202 N. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,	
Holly Woods C.A.	Aug 23	1929
20-UNDERTAKER.	ADDRESS	
C. Howard Evans	38 E Fort Ave	

instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

48696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 ✓

E 48696

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 14 E. Hamilton St. 16-67 Ward)

2-FULL NAME Philip Sheridan McLaughlin

(a) RESIDENCE NO. 3023 Littleton Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs.- mos.- ds. How long in U. S., If of foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) ---------

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Jos. V. McLaughlin

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. V. McLaughlin

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret O'Neill

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Leonard B. McLaughlin
(Address) 516 Cathedral Street

15 Filed AUG 23 1929, 19 HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1929 Found dead Aug 21 late

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound in brain. While suffering with mental depression

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted - If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. F. Tilly. M. D.

, 19 (Address) 1632 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/24 19 29
20 UNDERTAKER Henry W. Mears & Son	ADDRESS 305 N. Eutaw

DO NOT WRITE IN THIS SPACE

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48697

1-PLACE OF DEATH

City of Baltimore: (No. 1038 Hanover St. St.) 23-32 (Ward)

2-FULL NAME Thomas Kelly.

(a) RESIDENCE NO. 1038 Hanover St St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth 40 yrs. mos. ds.
(If non-resident give city or town and State)

90 E 48697

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced
HUSBAND of (~~WIFE of~~) Katherine Kelly.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland.
(State or country)

PARENTS

10 NAME OF FATHER Anthony E. Kelly.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Moran.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant John Kelly. (brother)
(Address) 631 Harvey St.

15 Filed AUG 3 1929 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic Disease of the Heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Steinhardt, M. D.

8/22. 1929 (Address) 1007 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Aug 24 1929
20 UNDERTAKER	ADDRESS
Margaret A. Flynn	1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48698

REGISTERED NO. E 48698

1-PLACE OF DEATH

City of Baltimore: (No. 889 W. Fayette St., 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Schaffer

(a) RESIDENCE NO. 889 W. Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 - 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Vegetable Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John C Schaffer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline E. Warwick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Robert E. Schaffer
(Address) 12 E. Carroll Ave

15 Filed AUG 23 1929 HARRISON JONES M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Keller, M. D.

8/23. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Aug 24 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 N Paca

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 48699

1—PLACE OF DEATH

REGISTERED NO. 92-43

CITY OF BALTIMORE: (No. 6201. Ridgeview. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Teresa. Schlauch.

(a) RESIDENCE NO. 6201. Ridgeview ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Schlauch

6 DATE OF BIRTH (month, day, and year) Nov. 1. 1908.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Moellmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Eva Straub

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mr John Schlauch

(Address) 1519 Henry St

15 Filed AUG 25 1929 E. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1929, to Aug 21, 1929.

that I last saw her alive on Aug 21, 1929.

and that death occurred, on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Lewis J. Klotz M. D.

19 (Address) 532 E 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 24 1929
20 UNDERTAKER	ADDRESS
Chas L. Grimes	1300 E Fort Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

Safran Yeselonis

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48700

CERTIFICATE OF DEATH

3 | E 48700

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 21-29 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Safron Yesilonis

(a) RESIDENCE NO. 1001 Bayard st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Tony Yesilonis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Annie Yesilonis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Hospital Records

(Address)

15 Filed AUG 23 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to August 21, 1929, that I last saw him alive on August 21, 1929 and that death occurred, on the date stated above, at 8.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Leo Arnold M. D.

8-22, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 24, 1929
20 UNDERTAKER	ADDRESS
Mr. Mrs. J. W. Teufel & Son	601 W Fayette

Spec.--2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48701

151 E 48701

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan Simms

(a) RESIDENCE NO. 1212 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63 ~~64~~			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records

(Address)

15 AUG 23 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/22/29

17 I HEREBY CERTIFY, That I attended deceased from 8/12, 1929, to 8/22, 1929, that I last saw her alive on 8/21, 1929 and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Gangrene left foot and lower left leg

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 8/14/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

8/22, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemy	Aug 24 29
20 UNDERTAKER: Geo T. A. Gahan	ADDRESS: 1735 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 48702

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 48702

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4511 Windsor Mill Rd. ST. 28-66 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Lazear Seth

(a) RESIDENCE NO. 4511 Windsor Mill Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 years yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of T. Alexander Seth

6 DATE OF BIRTH (month, day, and year) Apr. 10, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Jesse Lazear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Frances Burbridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Frances B. Seth

(Address) 4511 Windsor Mill Road

15 AUG 23 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-21-29

17 I HEREBY CERTIFY, That I attended deceased from 8/12 . 1929 . to 8/21 . 1929 .

that I last saw h[er] alive on 8/20 . 1929

and that death occurred, on the date stated above, at 2:50 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senility & arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) F. A. Sigrist, M. D.

. 19 (Address) 4409 Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug. 23, 19 29

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

M. D. Mitchell

Spec.—2-29-28—L. F. S.—500 Bks.

928360 E 48703

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48703

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 74 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mathilde Manly

(a) RESIDENCE NO. Eccleston - Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 - 1871

7 AGE: Years 58 | Months 5 | Days 27 | If LESS than 1 day, ...hrs. or ....min. (Days 26)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Wm Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Mary Bent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Reeds

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 23 1929 by HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1929, to Aug 22, 1929, that I last saw her alive on Aug 22, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Melanotic Sarcoma, Spine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 22-VIII-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E. H. Campbell, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem — DATE OF BURIAL: Aug 24 1929

20 UNDERTAKER: Henry H. Jenkins Sons — ADDRESS: Mt Auburn & Cleveland Sts.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48704

CERTIFICATE OF DEATH

11 V E 48704

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 123 Porgies bt St., 64 Ward)

2-FULL NAME John Dordy

(a) RESIDENCE NO. 123 Porgies bt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dordy

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) MD
(State or country)

PARENTS

10 NAME OF FATHER John Dordy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) MD

12 MAIDEN NAME OF MOTHER Emmer J Dean

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) MD

14 Informant Edward Spencer
(Address) molloy mch a.a.co.

15 Filed 6 23 1929 HAMPSON JONES, MD Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

bt Gastritis

(duration) — yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Pt Laustin

(duration) yrs. mos. 1 da.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H C Hadis M. D.

Aug 21 1929 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	aug 14 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans st

Spec.—2-29-28—L. F. S.—500 Blks.

Wiles

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48705

CERTIFICATE OF DEATH

+ 1775

E 48705

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Saratoga & Green ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Wiles

(a) RESIDENCE NO. Alberton, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11, 1928

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
#	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wilbur Wiles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Estelle Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Estelle Green (Address) Alberton, Md

15 AUG 23 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929 to Aug 23, 1929

that I last saw him alive on Aug 23, 1929

and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Stricture of oesophagus

(duration) yrs. mos. 29 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Aug 21, 1929

Was there an autopsy? no gastrostomy

What test confirmed diagnosis?

(Signed) W. B. Johnson, M. D.

Aug. 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Alberton Cem.

DATE OF BURIAL Aug 24, 1929

20 UNDERTAKER Easton Sons

ADDRESS Edmondale

Spec.—2-29-28—L. F. S.—500 Bks.

E 48706 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-002 E 48706

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 S. East ave ST., 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nettie Lorraine Skinner

(a) RESIDENCE NO. 922 S. East ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Leroy O. Skinner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Anna M. Atkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Anna M. Skinner

(Address) 922 S. East ave

15 Filed 8 23 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1929, to Aug 23, 1929, that I last saw h-x alive on Aug 23, 1929 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Dysentery Bacillary

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Horace B. Tillman, M. D.

8/23, 1929 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL Aug. 24 1929

20 UNDERTAKER George W. Zickler — ADDRESS 1737 E. Eager st.

Spec.–7-17-26—A Co.—200 Bks.

E 48707

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-29

CERTIFICATE OF DEATH

E 48707

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1947 W. Lafayette Ave St. 16-22 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Victoria Conroy

(a) RESIDENCE NO. 1947 W. Lafayette Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W.

5 Single, ~~Married, Widowed~~, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10, 1863

7 AGE Years 66 Months 2 Days 12 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Daniel Conroy

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs Edward Smith

(Address) 1947 W Lafayette Ave

15 Filed C. HAMPSON JONES, M. D.

Registrar

Per

2 5 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to Aug 22, 1929,

that I last saw h alive on Aug 21st, 1929,

and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 6 yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) L. A. Gordy M. D.

8-22, 1929 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery Date of Burial Aug 24 1929

20 UNDERTAKER Kellam & Love ADDRESS 1723 W Lafayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48708

CERTIFICATE OF DEATH.

E 48708

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2890 Kentucky ave ST. 8-46 WARD)

2-FULL NAME Harry M. Tremollen

(a) RESIDENCE NO. 2890 Kentucky Ave. ST.
(Usual place of abode) WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ deceased Dorothea Tremollen

6 DATE OF BIRTH (month, day, and year) 5. 21. 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Tremollen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Tremollen 2890 Kentucky Ave.

15 Filed 7-3-1929 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1929

17 I HEREBY CERTIFY, That I attended deceased from November 19 27 to August 21 19 29
that I last saw h[illegible] alive on August 21 19 29
and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease.
(duration) 1 yrs. 9 mos ds.

CONTRIBUTORY (Secondary) General Edema
(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. G. A. Moser, M. D.
8-27-29 19 29 (Address) 1038 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel	Aug 24-29

20 UNDERTAKER Jos. J. Stein & Son ADDRESS 516 Eutaw

TION is very important See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Bks.

Anna Walchter

E 48709

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 48709

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. ___ ST., 17-2 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Walchter Walchter (Walker)

(a) RESIDENCE NO. 762 George st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	64	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Illegible) (Address) Baltimore City Hospitals.

15 Filed 2 3 1929, 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22, 1929.

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1929, to August 22, 1929, that I last saw h[illegible] alive on August 22, 1929, and that death occurred, on the date stated above, at 0:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic and acute with Myocardial insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Signs & sympt.

(Signed) Warren H. [illegible] Lewis, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Brooklyn Md.	Aug 24 1929
20 UNDERTAKER Charles H Kehnen	ADDRESS 1332 Fulton

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48710

CERTIFICATE OF DEATH.

101-001

E 48710

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Providence Hospital St. 1-Wa WARD)

2-FULL NAME Roger Starkes

(a) RESIDENCE NO. 814 Druid ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 0410

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Friend (Address)

Filed AUG 20 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Aug 18, 1929, that I last saw h[illegible] alive on Aug 18, 1929, and that death occurred, on the date stated above, at 6 40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) George McDonald, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL: AUG 23 1929

20 UNDERTAKER [illegible] Smith. — ADDRESS

TION is very important See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48711

CERTIFICATE OF DEATH.

E 48711

1-PLACE OF DEATH Cutway from home to St. Agnes Hospital

CITY OF BALTIMORE: (No.) 2679 St. Benedict (St.) (Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Annie Canter.

(a) RESIDENCE NO. 2679 St. Benedict ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND ~~of~~ or) WIFE of Francis M Canter

6 DATE OF BIRTH (month, day, and year) 7. 23 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herbert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland

12 MAIDEN NAME OF MOTHER Elsie May

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Maryland

14 Informant (Address) Mrs Elsie Brown 2679 St Benedict Ste.

15 Filed Aug 26 1929 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1929, to Aug. 23, 1929, that I last saw h er alive on Aug 23, 1929, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Post partum hemorrhage

(duration) yrs. mos 2½ hrs ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? none needed

(Signed) Thos. P. Benson, M. D.

, 19 (Address) 2 N. Hilton St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Aug. 26 1929

20 UNDERTAKER George L. Schwab ADDRESS 2107 Eutaw Ave.

CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificates.

Spec.--1-10-21--M&T--1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48712
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

162

E 48712
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2101 Wilkens Ave ST. 70-72 (WARD)

2-FULL NAME June E. Hittel

(a) RESIDENCE NO. 2101 Wilkens Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-20-29

7 AGE — Years | Months | Days 3 | If LESS than 1 day, hrs. or min.
2

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS
10 NAME OF FATHER: George Hittel
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. City.
12 MAIDEN NAME OF MOTHER: Annie E. Bailey
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City.

14 Informant: Mrs. Annie E. Hittel
(Address) 2101 Wilkens Ave

15 Filed AUG 23 1929 HAMILTON JONES, M. D. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-20, 1929, to 8-23, 1929, that I last saw h/w alive on 8-22, 1929 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) asphyxia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

8/23, 1929 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westlawn Cemetery — DATE OF BURIAL: Aug 23 1929

20 UNDERTAKER: George L. Lohrwasser — ADDRESS: 2161 Fulk Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BIRTH is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48713

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48713

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 11524 38

CITY OF BALTIMORE: (No. ——— ST. ——— WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Choor

(a) RESIDENCE NO. 402 W. Hoffman St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	40	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Ofc

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) Washington D. C.
(State or country)

PARENTS

10 NAME OF FATHER George Choor

11 BIRTHPLACE OF FATHER (city or town) Washington D.C.
(State or country)

12 MAIDEN NAME OF MOTHER Mereb Smith

13 BIRTHPLACE OF MOTHER (city or town) Washington D. C.
(State or country)

14 Informant Records
(Address) Baltimore City Hospitals.

15 Filed AUG 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22/1929.

17 I HEREBY CERTIFY, That I attended deceased from August 7, 1929, to Aug. 22, 1929, that I last saw h[illegible] alive on August 22, 1929 and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute.
Syphilis 7 years.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy.

(Signed) Warren H. McClean, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	Aug 23, 29
20 UNDERTAKER Fitzhugh A. Redclen	ADDRESS 730 N. Biddle St.

Spec.—1-10-21—M&T—1500 Bks.

E 48714

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48714

CERTIFICATE OF DEATH.

+100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital W. Saratoga ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine Kimmick

(a) RESIDENCE NO. Cincinnati Ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene F

6 DATE OF BIRTH (month, day, and year) Mch 13 1865

7 AGE Years 64 Months 5 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louis J Tuhart

(Address) 325 E Preston St

15 Filed 1929 Geo. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23, 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/20, 1929 to 8/23, 1929.

that I last saw her alive on 8/22, 1929.

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia of unknown origin

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Virginia ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Exam + P.M.

(Signed) Theo. E. Stucy, Jr. M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cremation Chas DATE OF BURIAL 8/23/29

20 UNDERTAKER Thos A Kirby Fulton & Fayette ADDRESS

CAUSE OF DEATH to be plainly written, so that no two persons can read it alike. Do not use abbreviations or ditto marks. Any physician who refuses or neglects to fill out and sign this certificate, or who certifies to the cause of death without having personally attended the deceased, is liable to a fine of $100.00. See back of certificates. ATTENTION is very important.

Cor.—10-10-29—A Co.—100 Bks.

(Capriotti)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48715

179 E 48715

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3513 Gough St. 26-37 Ward)

2-FULL NAME Mary Capriotti (CAPRIOTTI)

(a) RESIDENCE NO. 3513 Gough St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 192[illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	2	-	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none W°
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Salt Lake City
(State or country)

PARENTS

10 NAME OF FATHER Biggs Capriotti

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Fannie Senatore

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Rena [illegible]olini
(Address) 3503 Gough St

15 Filed ....., 19.... HAMPSON JONES, M. D.
Registrar

23 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

3 Burns to body from
Crumbling & Pulmonary Collapse
Following Small water
Accident (duration) ....yrs. mo. 3 da.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted If not at place of death? 3513 Gough

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Hanson M. D.

8/23, 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	8/24 1929
20 UNDERTAKER	ADDRESS
Geo J Ruth	1735 Harford ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48716

31

E 48716

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1371 Gilmore St. 15-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Goldie Boyer

(a) RESIDENCE NO. 1371 Gilmore St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	28		-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) md

PARENTS

10 NAME OF FATHER Leo Hill

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Md.

14 Informant Mary Hill

(Address) 1371 N. Gilmore St

15 Filed 2 3 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-23-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 19, to Aug 22, 19 29.

that I last saw her alive on 8-22-29, 19,

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Leg ulcer)

Dr Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. R. Barham, M. D.

19 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

Accepted Blank

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bushwood Whf & Wks Co Date of Burial 8-24 1929

20 UNDERTAKER Ernest Eyrich ADDRESS Md 716 Ca

Sam'l Heath Sons & Mays Co

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 48717

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. 14-20 Ward)

2-FULL NAME Herbert Thompson

(a) RESIDENCE NO. 1435 Fremont St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		2 6	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work nn
(b) General nature of industry, business, or establishment in which employed (or employer) nn
(c) Name of employer nn

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Roman Thompson

11 BIRTHPLACE OF FATHER (city or town) Carrollton
(State or country) Md

12 MAIDEN NAME OF MOTHER Mamie Chance

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Mamie Thompson
(Address) 1435 N Fremont Ave

15 Filed AUG 23 1929 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 22nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) F. B. Link M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Cem	8-24-29

20 UNDERTAKER David Carton ADDRESS Fay 66

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48718 45 E 48718

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Mt. Holly ST. 20-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas P. O'Rourke

(a) RESIDENCE NO. 406 Mt. Holly ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida O'Rourke

6 DATE OF BIRTH (month, day, and year) May 29, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	54	2	24 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Business Manager

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer Steam Fitters Union

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael O'Rourke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hawkes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Ida O'Rourke
(Address) 406 Mt. Holly St.

15 Filed 8 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1928, to Aug. 22, 1929, that I last saw h... alive on Aug 22, 1929 and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Duodenum

(duration) yrs. 9 mos. 12 ds.

CONTRIBUTORY (Secondary) Carcinoma Duodenum

(duration) yrs. 9 mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 15-28

Was there an autopsy? No.

What test confirmed diagnosis? Frozen Section Path

(Signed) D Gar Bellis, M. D.

8/22 1929 (Address) 2224 W. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug. 26 1929
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48719

CERTIFICATE OF DEATH

40 E 48719

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1829 Edmondson Ave. ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leona Marie Brown

(a) RESIDENCE NO. 1829 Edmondson Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Brown

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes Edler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Joseph R. Edler
(Address) 1839 Edmondson Ave.

15 Filed Aug 23 1929, 19 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to Aug 22, 1929, that I last saw her alive on Aug 22, 1929, and that death occurred, on the date stated above, at 3.55 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M. D.

Aug 23 1929 (Address) 220 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug. 26 1929
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W. Baltimore St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48720

CERTIFICATE OF DEATH.

90 E 48720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 774 Mc Henry ST. 21-29 WARD)

2-FULL NAME Ferdinand Dehner.

(a) RESIDENCE NO. 774 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Marie E Denner

6 DATE OF BIRTH (month, day, and year) Feby 5, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58 yrs.	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer Bartlett Hayward

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mrs Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Denner

(Address) 774 McHenry St.

Filed AUG 25 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Aug 21, 19 24

that I last saw him alive on Aug 20, 19 29,

and that death occurred, on the date stated above, at 10.45a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & senile nephritis (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. W. MacMurray M.D.

8/24 1929 (Address) 2147 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Aug. 24 19 29

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 W. Baltimore St

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48721

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 8-17 Ward)

2-FULL NAME Annie Baker

(a) RESIDENCE NO. 1616 N. Chester St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 14/1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. City

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER August Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Margaret Maguire

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Mrs. Margaret Baker
(Address) 1616 N. Chester St

15 Filed 8 24 1929 19 C. HAMPSON JONES, M. D. (Registrar)
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poisoning
(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

8/23/29 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 8/26 1929

20 UNDERTAKER Albert I Hilz Jr — ADDRESS 1606 N Chester St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 24 ✓ E 48722

1—PLACE OF DEATH

REGISTERED NO. 12-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. ..... WARD)

2—FULL NAME Mrs. Florence McDaniel

(a) RESIDENCE NO. Easton (Usual place of abode) Maryland ST., ... WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. McDaniel

6 DATE OF BIRTH (month, day, and year) Sept 14 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Caulk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. McDaniel (Husband)

(Address) Easton Maryland

15 Filed 2 4 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 22, 1929, to Aug 23, 1929, that I last saw her alive on Aug 23, 1929 and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Meningococcus Meningitis

(duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Easton Md

Did an operation precede death? Spinal puncture Date of Aug 23 1929

Was there an autopsy? No

What test confirmed diagnosis? Spinal Fluid Examination

(Signed) Jesse L Tyler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton, Md.	August 26 1929
20 UNDERTAKER	ADDRESS
Stewart & Mowen Company	108 W. North St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48723

E 48723

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 938 Warner St. St., 21-31 (Ward)

2-FULL NAME Ada E. Vaughn. (C)

(a) RESIDENCE NO. 938 Warner St. St., _____ Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Femald	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 2, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	0	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Leon Vaughn. (C)

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Cambridge, Md.

12 MAIDEN NAME OF MOTHER Ruth Kane. (C)

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Cambridge, Md.

14 Informant Ruth Vaughn. (C)
(Address) 938 Warner St.

15 Filed 8-24 1929 C. HAMPSON JONES M. D. Registrar. By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry. (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

_____ (duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) _____

_____ (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No. Date of _____

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto M. Steinhardt, M. D.

8/28. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Aug 24 1929
20 UNDERTAKER	ADDRESS
Joseph A. Lisby	1098 N. Monroe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48724

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48724

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 5-S ST., 5-S WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest Barlog

(a) RESIDENCE NO. 909 W Central Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mary Barlog.

6 DATE OF BIRTH (month, day, and year) January 8th 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Barlog.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14
Informant Wards
(Address) Baltimore City Hospitals.

15
Filed ..... 19.....
HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22 19

17

I HEREBY CERTIFY, That I attended deceased from August 15, 19 29, to August 22, 19 29, that I last saw him alive on August 22, 19 29 and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home; Sunday visit.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Warren H. Wilson, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 26, 1929
20 UNDERTAKER Robt J. Turner	ADDRESS 1442 N Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48725

CERTIFICATE OF DEATH

113 E 48725

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3951 Roland Ave 43-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha May Dunner.

(a) RESIDENCE NO. 3951 Roland Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) May 7, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER Harry Dunner.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER May Russell.

13 BIRTHPLACE OF MOTHER (city or town) md.
(State or country)

14 Informant Harry Dunner.
(Address) 3951 Roland Ave

15 Filed 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1929, to Aug. 23, 1929.

that I last saw her alive on Aug. 22, 1929

and that death occurred, on the date stated above, at 11.25 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Gastro-Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Frank H Martin, M. D.

, 19 (Address) 4037 Falls Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Aug 24, 1929
20 UNDERTAKER	ADDRESS
Chenoweth Son	3615 Chestnut

Spec.—1-12-23—M&T—500 Bks.

E 48726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48726

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1613 E. Biddle ST. 8-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia C. Doyle

(a) RESIDENCE NO. 1613 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph P. Doyle Sr.

6 DATE OF BIRTH (month, day, and year) July 24, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work at

(b) General nature of industry, business, or establishment in which employed (or employer) Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gorhman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph P. Doyle Husband (Address) 1613 E. Biddle St

15 FILED 2 4 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/22, 1929, to 8/23, 1929, that I last saw her alive on 8/23rd, 1929, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. E. Gill, M. D.

, 19 (Address) 811 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery DATE OF BURIAL: Aug 27 1929

20 UNDERTAKER: Elmer W. Corkling ADDRESS: 924 E. Eager St.

FOR IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 48727 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St. Agnes Hospital. ST. 4-25 WARD) 44

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Lift.

(a) RESIDENCE NO. 314 N Green St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	~~Widowed~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Lift.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
59				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS
10 NAME OF FATHER John Lift.
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. Anna Lift.
(Address) 314 N. Greek St.

15 Filed 8 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-24 1929 to 8-23 1929
that I last saw him alive on 8-23 1929
and that death occurred, on the date stated above, at 1.15 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 7-29-29
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) George Brewer M. D.
, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New-Cathedral
DATE OF BURIAL 8/26 1929
20 UNDERTAKER H C Ramming Son
ADDRESS 1136 Bolton

TION is very important. See instructions on

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48728

CERTIFICATE OF DEATH

198 E 48728

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital 2331 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Tyree Carter.(C)

(a) RESIDENCE NO. 215 N. Henrietta St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married.

5a If married, ~~widowed or divorced~~ XXXXXXXXXX (or) WIFE of Milton Carter.(C)

6 DATE OF BIRTH (month, day, and year) July 2, 1900.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	29	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Tyree.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Anna Allen.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Anna Tyree.(C) mother.
(Address) Forschee P.O. Newkent Co. Va.

15 Filed 8 24 1929 C. HAMPSON JONES, M. D. Registrar
War Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) August 20, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquest. (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal hemorrhage due to a stab-wound of the abdomen involving the stomach. Homicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 218 N. Montgomery St. August 20, 1929.

Did an operation precede death? Yes. Date of Aug. 20, 1929

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquest.

(Signed) Otto M. Reinhardt, M. D.

8/22. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Point Va	Aug 24 1929
20 UNDERTAKER	ADDRESS
N. L. Brown & Son	West Point Va
Chesapeake S & C	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48729

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 48729

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp. ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Wallace

(a) RESIDENCE NO. 1644 W. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hamilton ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/21/29

17 I HEREBY CERTIFY, That I attended deceased from 4/22, 1929, to 8/21, 1929, that I last saw h[illegible] alive on 8/21, 1929 and that death occurred, on the date stated above, at 9[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Infectious arthritis, multiple

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No. Clinical

What test confirmed diagnosis?

(Signed) L. U. Lumpkin, M. D.

8/22, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT. Zion Ct	Aug 24 1929
20 UNDERTAKER	ADDRESS
A. L. Brown & Son	1818 Mont[illegible]

Spec.—1-12-23—M&T—500 Blks.

E 48730 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48730

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST., (WARD)

REGISTERED NO. 65

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Frederick

(a) RESIDENCE NO. 1703 N. Bradford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Carriage Painter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Christoph Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmini Bogus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Emma Flautt 1730 N Bradford St

15 Filed 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Aug 23, 1929

that I last saw him alive on Aug 23, 1929

and that death occurred, on the date stated above, at 3.45a.

The CAUSE OF DEATH* was as follows:

myeloid Leukemia

(duration) yrs 8 mos ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical and Laboratory

(Signed) J Kalogna, M. D.

, 19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 26 1929
20 UNDERTAKER Charles H Kellner	ADDRESS 1532 Hollins

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48731

CERTIFICATE OF DEATH

118-002

E 48731

1—PLACE OF DEATH

REGISTERED NO. 16-22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Franklin Sq. Hosp St., WARD)

2—FULL NAME Annie Elizabeth Coleman

(a) RESIDENCE NO. 1625 Mosher St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Williams Coleman

6 DATE OF BIRTH (month, day, and year) Dec 25 - 68

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	61	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. F. Tabb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Betty Miles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Conrad A Johnson

(Address) 726 E. Fillmore

15 Filed ....., 19 .... Registrar

C. HAMPSON JONES, M.

2 4 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23-29

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Aug 23, 1929,

that I last saw h.e.r alive on Aug. 23, 1929

and that death occurred, on the date stated above, at 8 35 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical picture

(Signed) Arthur Rathmell, M. D.

8/23 1929 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 26 1929
20 UNDERTAKER	ADDRESS
Sam F. Grace & Son	Mt Auburn

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48732

CERTIFICATE OF DEATH

+ 113

E 48732

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Hopkins Hospital St. 7-9 Ward)

2-FULL NAME Mildred Evelyn Watkins

(a) RESIDENCE NO. Pylesville, Harford Co., Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19/28

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pylesville
(State or country) Harfoer Co., Md.

PARENTS

10 NAME OF FATHER Edmund J. Watkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pylesville, Md.

12 MAIDEN NAME OF MOTHER Aleta A. Tush

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Harford Co., Md.

14 Informant Father
(Address) Pylesville, Md.

15 Filed ....., 19 C. HAMPSON JONES, M.D. Registrar

AUG 24 1929 By RRH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. L. Kellam, M. D.

8/24/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North Bend Cem	Aug 26 1929
20 UNDERTAKER	ADDRESS
E. E. Hutchison	Jarrettsville Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 48733 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48733

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 Bartlett Ave 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Julia Cecilia Sexton

(a) RESIDENCE NO. 618 Bartlett Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced (or) WIFE of: James Thomas Sexton

6 DATE OF BIRTH (month, day, and year): May 29-1859

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Dennis Horgan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Dennie Sexton
(Address) 618 Bartlett Ave

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar
Per .....

UG 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to August 22 1929.

that I last saw her alive on Aug. 22, 1929

and that death occurred, on the date stated above, at 8.45 P. M.

The CAUSE OF DEATH* was as follows: Chronic Bronchitis - Complete Heart Disease

(duration) 2 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F. Conry, M. D.

, 19 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Aug 26 1929

20 UNDERTAKER: Mary M. Waidner — ADDRESS: 20 E 22nd St

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Johnny Stevens

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 48734 E 48734

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1926

CITY OF BALTIMORE: (No. University Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Johnny Stevens

(a) RESIDENCE NO. 402 Myrtle Ave ST., WARD D.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? 44 yrs. 1 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Stevens

6 DATE OF BIRTH (month, day, and year) ? July 13 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Loading Ships

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sample Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Patient

(Address) 402 myrtle ave.

15 Filed AUG 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 20, 1929, that I last saw h in alive on Aug 20, 1929 and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Syphilis of Heart, Enlargement of Heart, Syphilis of Aorta & Aortic Insufficiency, Heart Failure Congestive (duration) 18 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure (Congestive

(duration) yrs. 2 mos. 20 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) W. Glenn Spitcher M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug. 24 1929
20 UNDERTAKER mrs Kate R. Williams	ADDRESS 3221 Johnson St

Cor.—10-10-29—A Co.—100 Bet.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48735

CERTIFICATE OF DEATH

3½ E 48735

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1217 Madison Ave 10-14 Ward)

2-FULL NAME Wilbur Robinson

(a) RESIDENCE NO. 1217 Madison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jas Robinson

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Mary Robinson
(Address) 1217 Madison Ave

15 Filed AUG 24 1929 E. STAMPER JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry)
find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
Sudden
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Phthisis
(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home,
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) Aug 23rd F. C. Zinck M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 24, 1929
20 UNDERTAKER	ADDRESS 327 N.
Mrs. Kate R. Williams	Schroeder St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48736

CERTIFICATE OF DEATH

1132

E 48736

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., Ward)

2-FULL NAME Juanita Jones

(a) RESIDENCE NO. 1032 E Monument St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	1	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Norris Jones

11 BIRTHPLACE OF FATHER (city or town) Anderson
(State or country) S. C

12 MAIDEN NAME OF MOTHER Nora Simpson

13 BIRTHPLACE OF MOTHER (city or town) Anderson
(State or country) S. C

14 Informant Norris Jones
(Address) 1326 Monument St

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Int. Rickets

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of
Was there an autopsy? Autopsy

What test confirmed diagnosis?

(Signed) W. E. Gladden, M. D.

19 (Address) 473 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Aug 25 1929
20 UNDERTAKER	ADDRESS
Byron & Wright	218 N Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificate.

AUG 25 1929 HAMPDEN-JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48737

CERTIFICATE OF DEATH

31 E 48737

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 28-63 ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Falb

(a) RESIDENCE NO. 4408 Belview ave. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? Unknown mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Falb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Marie Magine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to Aug. 22, 1929, that I last saw him alive on Aug. 22, 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) [illegible] M. D.

8-22-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 8/25 1929

20 UNDERTAKER John J. Fahey & Sons — ADDRESS 1318 Light St

Spec.—1-12-23—M&T—500 Blks.

48738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 48738

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. 6-9 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Kate Kushter

(a) RESIDENCE NO. 1634 E. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Abraham Kushter

6 DATE OF BIRTH (month, day, and year) December .

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Eisreal Walitzky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bintan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Baltimore St.

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/22, 1929, to 8/23, 1929, that I last saw her alive on 8/23, 1929, and that death occurred, on the date stated above, at 10-30 P m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis
From rupture of Sigmoid

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/22/29

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Kallan M. D.

8/24 19 29 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 8/25 19 29

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Anna Zwiegel ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

145-001

E 48739

CERTIFICATE OF DEATH

E 48739

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4-7 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Zwiegel

(a) RESIDENCE NO. 153 N. Gay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39 yr	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Hyman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Morris Zwiegel

(Address) 153 N. Gay St

15 Filed Aug 29, 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27/29

17 I HEREBY CERTIFY, That I attended deceased from 8/20/29, 19..., to 8/24/29, 19...

that I last saw her alive on 8/24/29, 19...

and that death occurred, on the date stated above, at 2:50 Am.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus following a Cesarean Section

..... (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/20/29

Was there an autopsy? no Clinical only

What test confirmed diagnosis?

(Signed) Wm N. McDaniel, M. D.

8/24 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Rest

DATE OF BURIAL 8/25 1929

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48740

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 4-17 Ward)

E 48740
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bartholomew E. Schott

(a) RESIDENCE NO. Perry Hall, Md St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna M. Schott

6 DATE OF BIRTH (month, day, and year) Feb 26/1890

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	39	5	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Co., Md

PARENTS

10 NAME OF FATHER Joseph Schott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Anna M. Schott
(Address) Perry Hall, Md.

15 Filed ... 19... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Comp. Fractire of Skull
Laceration & macer ation of
rt. Temp. Lobe of brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 22/29

Was there an autopsy? Yes at St. Joseph

What test confirmed diagnosis?

(Signed) J. H. Green, M. D.

8/24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's Cemetery	Aug 26 1929
20 UNDERTAKER	ADDRESS
Frederick Lassahn Sons	Fulton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C 5 1929 HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48741

CERTIFICATE OF DEATH.

49 E 48741

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4627 Keswick Road ST., 47-53 WARD)

2-FULL NAME Dr. Richard B. Norment

(a) RESIDENCE NO. 4627 Keswick Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

TION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Latchford Norment

6 DATE OF BIRTH (month, day, and year) Nov 14 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Medical 054

(b) General nature of industry, business, or establishment in which employed (or employer) Doctor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Richard B. Norment

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret T. Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Mrs Mary Latchford Norment

(Address) 4627 Keswick Road

15 Filed AUG 25 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) August 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug - 1 . 1929 . to Aug - 22 . 1929 .

that I last saw him alive on Aug 22 . 1929

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pleurisy with effusion, Probably metastatic

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate Gland (duration) 1 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 1928

Was there an autopsy? No

What test confirmed diagnosis? Operation and Physical Findings

(Signed) M. Gilmor Porter, M. D.

8/23 1929 (Address) 4622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Aug 26 1929

UNDERTAKER A. S. Marshall ADDRESS 3509 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48742

CERTIFICATE OF DEATH.

116-002

E 48742

1-PLACE OF DEATH Womans Hospital

REGISTERED NO. 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Martha McDonald

(a) RESIDENCE NO. 225 West 23rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 35 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Michael J. McDonald

6 DATE OF BIRTH (month, day, and year) April 17 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 057

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Limerick Ireland

PARENTS

10 NAME OF FATHER John Keys

11 BIRTHPLACE OF FATHER (city or town) Limerick (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nellie McCarthy

13 BIRTHPLACE OF MOTHER (city or town) Limerick (State or country) Ireland

14 Informant Mrs. Ellen Plopper (daughter)

(Address)

15 Filed AUG 25 1929 C. HARRISON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1929, to Aug 23, 1929, that I last saw h[illegible] alive on Aug 23, 1929, and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows: Intestinal obstruction

(duration) yrs. ..... mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Aug 23, 1929

Was there an autopsy? No

What test confirmed diagnosis? Of [illegible]

(Signed) Chas. G. Hardy M. D.

8/23, 1929 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 8/26, 1929

20 UNDERTAKER J. Walter Davis

ADDRESS 330 Fremont

CAUSE OF DEATH must be plainly written. See other side for instructions. Use only one line for each cause. Do not use abbreviations or ditto marks. Do not report conditions which did not contribute to the death. Do not report modes of dying, such as heart failure, asphyxia, anemia, or uremia. Do not report merely symptoms, such as pain, weakness, or convulsions. Do not report indefinite terms, such as cancer, tumor, stroke, or paralysis. Be sure to report the primary cause, that is, the disease or injury which initiated the train of morbid events which resulted directly in death. Operations should be reported only when performed for some other cause than that which caused death. Write plainly with pen and ink and use only standard medical terms and abbreviations. Punctuation is unnecessary. Make a separate report for each death. Do not fail to answer every question. If there is no medical attendant, the coroner must certify to the cause of death. When death is due to external causes (violence), fill in also the following: Accident, suicide, or homicide? How injury occurred? Was injury work connected? Where did injury occur? (Specify whether in home, factory, street, office building, etc.) Date of injury? TIME is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48743

CERTIFICATE OF DEATH

E 48743

1—PLACE OF DEATH Balto City Hospls. REGISTERED NO. 38

CITY OF BALTIMORE: (No. Balto Ind. ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Tecato

(a) RESIDENCE NO. 1111 N. Carrollton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Tecato

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Charles Tecato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Clara Poulson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Balto City Hospl
(Address) Balto Ind.

15 Filed AUG 25 1929, 19 [illegible] Registrar

HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/22/29

17 I HEREBY CERTIFY, That I attended deceased from 5/8/, 1929, to 8/22, 1929, that I last saw h. alive on 8/22, 1929, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Lueic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological & Typical findings

(Signed) Harry Tildesley M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crancock Va	Aug 25 1929
20 UNDERTAKER	ADDRESS
Samuel Kemsley	576 Biddle

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48744

CERTIFICATE OF DEATH

E 48744

1—PLACE OF DEATH

REGISTERED NO. 25-65-74-002

CITY OF BALTIMORE: (No. 1001 Mosher Park Terrace ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugenia Travers

(a) RESIDENCE NO. 1001 Mosher Park Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late, William M. Travers

6 DATE OF BIRTH (month, day, and year) July 20, 1848

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
81	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Meekins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dr. Edgar E. Travers

(Address) 1001 Mosher Park Terrace.

15 Filed AUG 25 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 - 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 22, 1929.

that I last saw h-W alive on Aug 22, 1929.

and that death occurred, on the date stated above, at 11.40 p. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis and Cerebral Embolism

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Harry M. Stein M. D.

Aug 24 1929 (Address) 104 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug. 26 19 29

20—UNDERTAKER Harry Nitzke ADDRESS 531 N. Lombard St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48745

CERTIFICATE OF DEATH

90 E 48745

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 N. Clinton St. ST. 26-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna K. Sinners

(a) RESIDENCE NO. 28 N. Clinton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of James R. Sinners

6 DATE OF BIRTH (month, day, and year) Mar. 17/1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Conrad Weitzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magealene Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fannie Sinners

(Address) 28 N. Clinton St.

15 Filed Aug 25 1929 19 C. H. Addison Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23/29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1929, to Aug 23, 1929, that I last saw h alive on Aug 23, 1929 and that death occurred, on the date stated above, at 4,45 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Th. Artigiani, M. D.

, 19 (Address) 2942 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Aug. 26/29

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans ST.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48746 — REGISTERED NO. E 48746

161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 N. Schroeder St. Ward) 18-7b

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bullock

(a) RESIDENCE NO. 125 N Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21, 1929.

7 AGE Years Months 1 Days 13 — 34

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Premature birth

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Bullock

11 BIRTHPLACE OF FATHER (City or town) N C

(State or country)

12 MAIDEN NAME OF MOTHER Edwina Pullen

13 BIRTHPLACE OF MOTHER (city or town) [illegible]

(State or country) [illegible]

14 Informant John Bullock

(Address) 125 N Schroeder St

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24 1929

17 I HEREBY CERTIFY, That I attended deceased from July 21 1929, to Aug 24 1929, that I last saw him alive on Aug 24 1929, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) ..... yrs. ..... mos. 34 da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. H. Hawkins M. D.

19 (Address) 1212 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Auburn	Aug 25 1929
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 25 1929 C. HUBERT JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48747

CERTIFICATE OF DEATH

44 E 48747

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST. 19-28 WARD)

2—FULL NAME Robert Wareham

(a) RESIDENCE NO. 1418 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Wareham

6 DATE OF BIRTH (month, day, and year) Dec 18 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	41	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Elizabeth Wareham

(Address) 1418 W Lombard St

15 Filed 2 9 1928, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Aug 24, 1929.

that I last saw him alive on Aug 24, 1929

and that death occurred, on the date stated above, at 3 29 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bile ducts - (Common, Cystic & Hepatic)

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Aug 15, 1929 Cholecystotomy

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) W. D. Plenaker, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Aug 26 1929
20 UNDERTAKER	ADDRESS 1203
Henry Lutz	N. Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48748

CERTIFICATE OF DEATH

+1702

E 48748

REGISTRATION NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 737 E Biray St., 2-4 Ward)

2-FULL NAME Chas F. Hiraueh

(a) RESIDENCE NO. Essex Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Meraueh

6 DATE OF BIRTH (month, day, and year): March 16-1881

7 AGE: Years 43 | Months 5 | Days 8 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): 016
(c) Name of employer: Self

9 BIRTHPLACE (city or town)
(State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Martha Berke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany

14 Informant: Margaret Meraueh
(Address): Essex Md

15 Filed ....., 19..... Registrar

AUG 25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest autopsy or inquiry.
(Inquest, autopsy or inquiry.)
Coroner and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide
Gunshot of head (Pistol)
(duration) ..... yrs. ..... mos. — ds.
CONTRIBUTORY (Secondary) Locks.
(duration) ..... yrs. ..... mos. / ds.

18 Where was disease contracted if not at place of death?
Did any operation precede death? — Date of —
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) J. C. Ed ades M. D.
2 Sept. 19 29 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: 8/27 1929

20 UNDERTAKER: Inman Co's — ADDRESS: 219 N Paca

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—50

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48749

CERTIFICATE OF DEATH

105 V

E 48749

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 347 E 29th ST., 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Archibald Ferguson Holt

(a) RESIDENCE NO. 347 E 29th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or ~~Divorced~~. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Mrs Sarah J Holt

6 DATE OF BIRTH (month, day, and year): April 7-1867

7 AGE: Years 62 | Months 4 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): Anchorage

(c) Name of employer: E. J. Norell

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Sarah J Holt

(Address): 347 E 29th

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1929, to Aug 24, 1929, that I last saw h[im] alive on Aug 23, 1929, and that death occurred, on the date stated above, at 3 1 m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma & Emphysema

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward L Carroll M. D.

8/24 1929 (Address) 418 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Aug 26 1929

20 UNDERTAKER: McAdam Co Inc — ADDRESS: 211 St Paul

AUG 29 1929 HAMPTON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 49 E 48750

1—PLACE OF DEATH Lemmuty Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Green ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mike Seelinger

(a) RESIDENCE NO. Raleigh W. Va. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Seelinger

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Miner

(b) General nature of industry, business, or establishment(in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) East Va

PARENTS

10 NAME OF FATHER Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va W Va

14 Informant John Henley
(Address) Raleigh W. Va

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24/29.

17 I HEREBY CERTIFY, That I attended deceased from 7/19 . 1929. to 8/24 . 1929

that I last saw him alive on 8/23 . 1929

and that death occurred, on the date stated above, at 4-05 a.m..

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas
Total duodenal obstruction

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Mesenteric Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/22/29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Richard E. Hall, M. D.

. 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Beckley W. Va	Aug 25 1929
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—1-12-23—M&T—500 Blks.

E 48751 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 48751

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH 11 Mallow Hill Ave REGISTERED NO. 28-71

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl F. Genning

(a) RESIDENCE NO. 11 Mallow Hill Ave ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 39 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Genning

6 DATE OF BIRTH (month, day, and year) May 9 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	39	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co

PARENTS
10 NAME OF FATHER Wm H. Genning
11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co
12 MAIDEN NAME OF MOTHER Isabella Sisco
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Edna Genning (Address) 11 Mallow Hill Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1929, to Aug 23, 1929, that I last saw him alive on Aug 23, 1929, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) 4 yrs 6 mos d

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Harford Co

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) F. F. Kyper, M. D.

, 19 (Address) 3321 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

Marscott Stan, Ellicott City, Md

AUG 23 1929 C. HARRISON JOHNS, M.D.

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

48752 ✓ 90 E 48752

E 48752

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Wirth

(a) RESIDENCE NO. 1714 N. Castle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 5 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	69	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster.

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Produce

(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Wirth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records Baltimore City Hospitals.

(Address)

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23, 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to August 23, 1929, that I last saw him alive on August 23, 1929 and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute with myocardial insufficiency.

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy.

(Signed) Marvin M. Smith M. D.

. 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 26 19 29
20 UNDERTAKER	ADDRESS
H. S. Wyland	650 N. Carey St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48753

CERTIFICATE OF DEATH

X 65-001

REGISTERED NO. E 48753

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 Ridgewood Road ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Stern

(a) RESIDENCE NO. Uniontown, Penna ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 11 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 14, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	64	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal operator

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Julius Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lee Stern

(Address) Uniontown Penna

15 Filed ... 19 ... Registrar

AUG 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to Aug. 25, 1929.

that I last saw him alive on Aug 25, 1929

and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Leukemia (myelocytic)

(duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Uniontown, Penna.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam of blood

(Signed) John A. Treacher, M. D.

19 (Address) 1035 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Uniontown Pa	Aug 26 1929
20 UNDERTAKER	ADDRESS
Henry A. Jenkins Sons Co	21 Cullot Courthouse Md

Spec.—1-12-23—M&T—500 Bks.

E 48754 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 E 48754

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No.) Broadway (ST.) (WARD) D.1

REGISTERED NO. 16-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lina Droney

(a) RESIDENCE No. 1719 Harlem ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of L. J Droney

6 DATE OF BIRTH (month, day, and year) April 29 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Chas David Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Martha Hargo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant Charles D Miles

(Address) 1719 Harlem Ave

15 Filed 19 Registrar

G 26 1929 W. H. MIMPSON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1929, to Aug 26, 1929, that I last saw h[illegible] alive on Aug 26, 1929, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of frontal bone the result of frontal sinusitis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Emmett Wallace, M. D.

Aug 26 1929 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenville, S C — DATE OF BURIAL Aug 28 1929

20 UNDERTAKER Wm J Dickson Sons — ADDRESS N Pa Ave

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48755

188-203

E 48755

1-PLACE OF DEATH

City of Baltimore: (No. So. Balto G. Hosp St. 25-27 Ward)

2-FULL NAME Thomas F. Clark Sr

(a) RESIDENCE NO. 1503 Curtis Av St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Nora Clark

6 DATE OF BIRTH (month, day, and year) June 11 1882
Nora Clark

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47	2	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Trades Building
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Jos Clark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Azzella Martin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Nora E. Clark
(Address) 1503 Curtis ave

15 Filed AUG 26 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows: Comp. Comm. Fract. Skull

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Traumatic shock

(duration) yrs. mos. da.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) P. J. Fraun M. D.

8/25 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 8/27 1929

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1422 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48756

CERTIFICATE OF DEATH

188-703

E 48756

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Go. Batto Hosp St. 25-77 Ward)

2-FULL NAME Simmons E. Clarke Jr

(a) RESIDENCE NO. 1503 Curtis Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 16-1909

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	20	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter Helper
(b) General nature of Industry, business, or establishment in which employed (or employer) Building Trades
(c) Name of employer 015

9 BIRTHPLACE (city or town)
(State or country) Balto md

PARENTS

10 NAME OF FATHER Simmons T Clark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Mc Gauty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant Mrs Nora Clark.
(Address) 1503 Curtis Ave

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Laceration Complete of Trachea

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. T. Frame M. D.

8/25. 1929 (Address) 29 Eighth Ave Edgewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	8/27 1929
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88-103

E 48757

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. So. Balto Hosp St. 23-34 Ward)

2-FULL NAME Wm N. Sebra

(a) RESIDENCE NO. 1736 Light St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Oct-21-1926

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	2	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Llewellyn Sebra

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Millett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Sebra.
(Address) 1736 Light St

15 Filed AUG 26 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest find that said deceased came to his death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture base of skull

..... (duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + X ray

(Signed) B. J. Frame M. D.

8/25. 1929 (Address) 2939 1/2 Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	8/27 1929
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light

OF DEATH in plain terms, so that it may be of property classified. Exact statement of cause is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks. Angrish McPherson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48758 33 ✓ E 48758

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Angus McPherson

(a) RESIDENCE NO. 1424 E Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where [illegible] mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy McPherson

6 DATE OF BIRTH (month, day, and year) [illegible] 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) unknown
(State or country) North Carolina.

PARENTS

10 NAME OF FATHER Henry McPherson

11 BIRTHPLACE OF FATHER (city or town) unknown.
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Lola Gilton

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country) North Carolina.

14 Informant (Address) Balto City Hosp. Phone

15 Filed ..... 19 ..... Registrar

G. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-24-29

17 I HEREBY CERTIFY, That I attended deceased from 8-19-, 1929, to 8-24-, 1929, that I last saw h[illegible] alive on 8-24- 1929 and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Intestinal peritonitis

(duration unknown mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? yes. Date of 8-20-29

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) Fred M. Dunbar M. D.

. 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkton N. C	aug 27 19 29
20 UNDERTAKER Edward Bryan	ADDRESS 1681 orleans st

Spec.—2-29-28—L. F. S.—500 Blks.

E 48759
2285089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1476

E 48759

1—PLACE OF DEATH

REGISTERED NO. 15-21

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Dans Ward

(a) RESIDENCE NO. 1708 Westwood Ave ST., ... WARD
(Usual place of abode) Unknown
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arvin Dans

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sadie Nickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

JOHNS HOPKINS HOSPITAL JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24-1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Aug 27, 1929

that I last saw h[illegible] alive on Aug 24, 1929

and that death occurred, on the date stated above, at 5-55 p. m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Rupture of tubal abscess

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 13, 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. G. Douglas, M. D.

8/25, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
White Stone Va	Aug 27 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans st

Cor.—10-10-29—A Co.—100 Bks.

Stroebener

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48760

1-PLACE OF DEATH

City of Baltimore: (No. 3053 Brighton St., 16-67 Ward)

2-FULL NAME Mary Stroebener

(a) RESIDENCE NO. 3053 Brighton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74001

E 48760

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Stroebener

6 DATE OF BIRTH (month, day, and year) Sept 20—1852

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	75	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Augus Schaefer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Wilhemina Zimmer

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mary Stroebener
(Address) 3053 Brighton St.

15 Filed AUG 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) yrs. Suddem

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) Aug 23rd Herbert Conner, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	8/29 1929.
20 UNDERTAKER Geo Sinclair & Son	ADDRESS 2001 N Gilmor

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 48761

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48761

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Gorsuch Ave ST., 9-46 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Cecilia Plowman

(a) RESIDENCE NO. 1527 Gorsuch Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Stephen Plowman

6 DATE OF BIRTH (month, day, and year) July 2, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	32	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Lawrence Sinnott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Guerin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Stephen H. Plowman
(Address) 1527 Gorsuch Ave.

15 Filed ..... 19 .....
Per C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to Aug. 23, 1929, that I last saw her alive on Aug. 23, 1929, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of bladder (secondary to cancer of uterus - operation Jan. 1926)

about 1 yrs. — mos. — ds. (duration)

CONTRIBUTORY (Secondary) Acute nephritis

(duration) — yrs. — mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. W. Bacon, M. D.

8/24, 1929 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Cemetery Aug. 28 1929

20 UNDERTAKER — ADDRESS

Elmer W. Conklin 224 E. Eager

CAUSE OF DEATH must be filled in plainly and completely. See instructions on back of certificates. ATTENTION is very important.

G 26 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48762

1-PLACE OF DEATH

129

E 48762

REGISTERED NO.

City of Baltimore: (No. 1511 N. Washington St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles R. Dashiell

(a) RESIDENCE NO. 1511 N. Washington St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. da. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	59	9	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles E. Dashiell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Susie Cadamore

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Elmer E. Dashiell
(Address) 334 Smallwood St

15 Filed AUG 26 1929 HAMILTON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History & exam.

(Signed) J. S. Thomas, M. D.

8/20/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Aug 27 1929
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 E. Gay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

Pletka

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48763

CERTIFICATE OF DEATH

31 E 48763

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 946 N. Durham St., 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Pletka

(a) RESIDENCE NO. 946 N. Durham St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo Pletka

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	73			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Peter Paul

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia.

14 Informant Leo Pletka

(Address) 1924 Edmondson Ave

15 Filed ..... 19 .....

AUG 25 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

8-23-29

17 I HEREBY CERTIFY, That I attended deceased from 8-20 19 29 to 8-23-29 19 .

that I last saw her alive on 8-23-29 19 .

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Hallinan M. D.

8-25-1929 (Address) 2214 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Holy Redeemer — Date of Burial 19

20 UNDERTAKER — Send Bros. — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48764

CERTIFICATE OF DEATH

15 E 48764

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 802 W 35th St. ST., 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert N. Mason

(a) RESIDENCE NO. 802 W 35th St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug 2, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. M.D.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Wilbut Mason

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Spitzler

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Wilbut Mason
(Address) 802 W 35th St

15 Filed Aug 26, 1929 J. HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 2/29, 19..., to Aug 24/29, 19..., that I last saw h him alive on Aug 24/29, 19..., and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. H. Owen, M. D.

8/20/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden	Aug 26, 1929.
20 UNDERTAKER	ADDRESS
Ehemowithson	1415 Hunt St

important. See instructions on back of certificates.

Spec.—2-29-28—1-5[illegible]ka.

E 48765

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 48765

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST. 14-22 ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Noah Handy

(a) RESIDENCE NO. 2027 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records
(Address): Baltimore City Hospitals.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to August 23, 1929, that I last saw h[illegible] alive on August 23, 1929, and that death occurred, on the date stated above, at 8:00 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and hypertension; Unknown: (Many years)
Chronic nephritis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Primary in Hospital; Secondary [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General exam.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[redacted] Auburn	8/26/1929
20 UNDERTAKER	ADDRESS
Mrs. Geo. H. Holland	1631 Druid Hill

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48766

CERTIFICATE OF DEATH

E 48766

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) En route to University Hospital (or Ward)

2-FULL NAME Ollie Green

(a) RESIDENCE NO. 947 W. Franklin St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lula Green

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O+O
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Lula Green
(Address) 3404 Drumon Ave

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

8/27. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 8/27/1929

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Enter statement of OCCUPATION, if important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

E 48767 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 11 E West St. (St.) 23-33 (Ward) 4th Registered No.

2-FULL NAME Charles W. Jenkins.

(a) Residence No. 11 E. West St. (Usual place of abode) Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White.

5-(Single,) Married, (Widowed,) (Divorced,) (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Jenkins.

6-DATE OF BIRTH (month, day and year) Oct 8, 1892

7-AGE. 37 yrs. 6 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Fireman 232

(b) General nature of industry, business, or establishment in which employed (or employer). City of Balto

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. John L. Jenkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER. Mary Nelson.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md.

14-

(Informant) Mrs. Evelyn Jenkins

(Address) 11 E. West St.

15-

AUG 26 1929 192

FRANK HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 24, 1929

17- I HEREBY CERTIFY, That I attended deceased from June 1, 19 27 to Aug 24, 19 29

that I last saw him alive on Aug 23, 19 29

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of June 1, 1927

Was there an autopsy? No

What test confirmed diagnosis? Autopsy from Operation

(Signed) Frank H. Anderson M. D.

Aug 25, 1929 (Address) 115 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cem. DATE OF BURIAL. Aug 27, 1929

20-UNDERTAKER. Fred A. Kahnweiler ADDRESS 783 L. Howard

instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48768

CERTIFICATE OF DEATH

E 48768

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. 30-64

CITY OF BALTIMORE: (No. ..... ST. ..... (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Leona Eberhart

(a) RESIDENCE NO. 2587 W. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced (or) WIFE of Joseph Eberhart

6 DATE OF BIRTH (month, day, and year) 5/30/93

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Gustav Graubner

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Marie Engelhart

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/25/29

17 I HEREBY CERTIFY, That I attended deceased from 7/17, 1929, to 8/25, 1929, that I last saw her alive on 8/25, 1929 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Perinephritic abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/23/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm N. McFarland, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 28 1929
20 UNDERTAKER Charles H. Keelmer	ADDRESS 1582 Hallins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48769

CERTIFICATE OF DEATH

129

REGISTERED NO. **E 48769**

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. Mt Hope Retreat ST. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Killeen

(a) RESIDENCE NO. Mt Hope Retreat ST., unknown WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. (mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Single

6 DATE OF BIRTH (month, day, and year) Aug 3. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer): Religious 065

(c) Name of employer: Religious

9 BIRTHPLACE (city or town) (State or country): unknown Louisiana

PARENTS

10 NAME OF FATHER: Thomas Killeen

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown Ireland

12 MAIDEN NAME OF MOTHER: Mary Monaghan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Ireland

14 Informant: Mt Hope Records

(Address): Mt Hope Retreat.

15 Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Aug 24, 1929, that I last saw her alive on Aug 24, 1929 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Chr. Interstitial Nephritis)

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile dementia

unknown (duration) — yrs — mos. — da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Hope Cemetery	August 27 1929
20 UNDERTAKER	**ADDRESS**
Stewart & Mowen Company	108 W. North Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48770

CERTIFICATE OF DEATH

57 E 48770

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 9 N. Port ST., 6-10 WARD)

2—FULL NAME Catherine Bachmann

(a) RESIDENCE NO. 9 N. Port ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Bachmann.

6 DATE OF BIRTH (month, day, and year) Feb 14 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	6 7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Logue

11 BIRTHPLACE OF FATHER (city or town) U. S.
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) U. S.
(State or country)

14 Informant Frank Bachmann
(Address) 9 N. Port St.

15 Filed AUG 29 1929, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27/29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1928, to Aug. 27, 1929, that I last saw h[er] alive on Aug. 27, 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

Aug 27 1929 (Address) 701 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	aug 29 1929
20 UNDERTAKER Lilly & Zeiler Inc	ADDRESS 408 S. Wolfe St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48771

E 48771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital

REGISTERED NO. 129

CITY OF BALTIMORE: (No.) ST. 2-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Zimmerman

(a) RESIDENCE NO. 326 S. Chattel ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55	55	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman - 21

(b) General nature of industry, business, or establishment in which employed (or employer) work.

(c) Name of employer S S Wasarto -

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER W. L. Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clinical records -
(Address) U.S. Marine Hospital

15 Filed AUG 26 1929 19 C. HAMPTON JONES, M. D. Registrar
For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1929

17

I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to Aug 24, 1929, that I last saw h(im) alive on Aug 24, 1929, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) Ralph L Pelot M. D.

19 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	Aug. 27 1929
20 UNDERTAKER	ADDRESS
Lilly & Friend	400 S. Wolfe St

CAUSE OF DEATH must be filled in by physician. See instructions on back of certificates.
TION is very important.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 48772

1—PLACE OF DEATH South Balto Gen Hosp REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. Gurley

(a) RESIDENCE NO. 1536 Byrd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. · How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Odie Gurley

6 DATE OF BIRTH (month, day, and year) Jan 1 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	years	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Gurley

(Address) 1536 Byrd al.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1929, to Aug 25, 1929, that I last saw him alive on Aug 25, 1929, and that death occurred, on the date stated above, at 1 22 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

Cardio vascular Renal disease ?

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Uraemia

Suicide admitted (duration) ... yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lab reports.

(Signed) E. A. Fitzinger, M. D.

, 19 (Address) 1213 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	8/28 1929
20 UNDERTAKER	ADDRESS
J. Fem McCully	130 E. Fort

HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48773

CERTIFICATE OF DEATH

× 46 E 48773

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 18 N. Franklin ST., 11-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta J. Ohlmeyer

(a) RESIDENCE NO. 7120 Sheffield Road WARD

(Usual place of abode) (If not a resident give city or town and State) Stoneleigh

Length of residence in city or town where death occurred 18 yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	widow

6a If married, widowed or divorced HUSBAND of (or) WIFE of J. Henry Ohlmeyer

6 DATE OF BIRTH (month, day, and year) Aug 20 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Fred. Muthert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr. E. J. Ohlmeyer

(Address) 706 Park Bank Bldg

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25. 29

17 I HEREBY CERTIFY, That I attended deceased from May, 19 29, to Aug 25, 19 29.

that I last saw h alive on Aug 24, 19 29

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma melora

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral abscess.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? yes. Date of 5/24/29

Was there an autopsy? No.

What test confirmed diagnosis? Pathological specimen.

(Signed) Thos. E. Schumacher, M. D.

, 19 (Address) 18 N. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 27 19 29
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1225 Eutaw Pl.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48774

CERTIFICATE OF DEATH

161-01

E 48774

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Walker

(a) RESIDENCE NO. 3122 Guilford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. or 55 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Alfred J. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Catherine Kaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Mother

(Address) 3122 Guilford Ave.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Aug 25, 1929.

that I last saw her alive on Aug 25, 1929

and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Premature Baby

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm N McFaul Jr, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Newbath-bem	5/24 19 29
20 UNDERTAKER J. J. Moran	ADDRESS 30- E Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48775 CERTIFICATE OF DEATH 31 E 48775

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 18-26 ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daisy Christy

(a) RESIDENCE NO. 917 Mulberry st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Steven Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records
(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to August 22, 1929, that I last saw h.. alive on August 22, 1929 and that death occurred, on the date stated above, at 7.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Jas Garnett M. D.

8-22 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Aug 26 19 29

20 UNDERTAKER — ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48776 ✓ E 48776

E 48776 CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T. B.) REGISTERED NO. 7331 31

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Nichols

(a) RESIDENCE NO. 1008 Peach Alley ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Nichols

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jackson Melburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Carrie Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 19 29, to Aug. 21, 19 29, that I last saw him alive on Aug. 21, 19 29 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Jas. Gilmore D. M. D.

8-21 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL Aug 26 19 29

20 UNDERTAKER ..... ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health

Spec.—1-10-21—M&T—1500 Bks.

Daniel H. Barnard.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48777

CERTIFICATE OF DEATH.

100-001

E 48777

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Pine St. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Barnard

(a) RESIDENCE NO. 808 Pine ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1/24/1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Luther Barnard

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Heath Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Father (Address) 808 Pine St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24/29

17 I HEREBY CERTIFY, That I attended deceased from 8/19/29 19 to 8/24/29 19

that I last saw h[illegible] alive on 8/24/29 19

and that death occurred, on the date stated above, at 9 Hrs. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 10 da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 92 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid N. C.	Aug 26 29
20 UNDERTAKER Byron A. Wright	ADDRESS 1217 McElderry

CAUSE OF DEATH must be filled in. See instructions on back of certificates.

TION is very important.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48778 — 40 — E 48778

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4200 Curtis Ave. Curtis Bay-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME REV Cazimer Polianski

(a) RESIDENCE NO. 4200 Curty Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) NO. 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Priest 018

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No.

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER No

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant K. Yekubatis
(Address) 4200 Curty Ave

15 Filed ..... 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20 , 1929 , to Aug. 23 , 1929.

that I last saw him alive on Aug. 22 , 1929

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) R. Adam , M. D.

, 19 (Address) 2201 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.A.	Aug. 27, 1929
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St.

AUG 26 1929 HAMPSON JONES, M. D.

TION IS very important. See instructions on back

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48779

CERTIFICATE OF DEATH

90

E 48779

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 25-12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Blanche Razgaitis

(a) RESIDENCE NO. 1609 Spence ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 1 mos. 21 ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) Taylor Shop

(c) Name of employer (?)

9 BIRTHPLACE (city or town) (State or country) Balt md

PARENTS

10 NAME OF FATHER Carl Razgaitis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Mary Grius

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Carl Razgaitis

(Address) 1609 Spence St

15 Filed [illegible], 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1929, to Aug 27, 1929, that I last saw her alive on Aug 24, 1929, and that death occurred, on the date stated above, at 3.50 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis and myocarditis, Acute,

(duration) 1 yrs. 7 mos. (?) ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal Pneumonia).

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) [illegible] M. D.

. 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	AUG. 28. 1929

20 UNDERTAKER John Grebliauckas J.G.

ADDRESS 423 S Paca St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48780

CERTIFICATE OF DEATH

129

E 48780

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3617 Ferndale Ave. ST. 28-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Pladas

(a) RESIDENCE NO. 3617 Ferndale Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Anthony Pladas

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of indostry, bosiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Michael Dawksho

(Address) 3617 Ferndale Ave.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24/29

17

I HEREBY CERTIFY, That I attended deceased from June., 19 29, to Aug 24, 19 29,

that I last saw h alive on Aug 23, 19 29

and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ..... yrs. ..... mos. 12 hrs. ds.

CONTRIBUTORY (Secondary) Cardio-renal.

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical course + Labor

(Signed) J. H. Zieler, M. D.

Aug 26, 1929 (Address) 701 Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemeter	8/27/29

20 UNDERTAKER J. Carroll Mitchell ADDRESS 3400 Eastern Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48781

CERTIFICATE OF DEATH

129 E 48781

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 14 N. Stricker St. ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Cole

(a) RESIDENCE NO. 14 N. Stricker St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late, Joseph H. Cole

6 DATE OF BIRTH (month, day, and year) August 20, 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Killalea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Barron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary A. Cole

(Address) 14 N. Stricker St.

15 Filed AUG 26 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1929, to Aug 24, 1929, that I last saw h[illegible] alive on Aug 24, 1929 and that death occurred, on the date stated above, at 11 4 m.

The CAUSE OF DEATH* was as follows:

Chronic Dat. Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Urine Exam.

(Signed) Chas. Norton, M. D.

8/26, 1929 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	8/27/29 19

20 UNDERTAKER Fany & Witzke, 531 W Lombard St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 48782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89

E 48782

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 E. Chase ST. 10-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Elizabeth M. Vincent

(a) RESIDENCE NO. 841 E. Chase ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Halifax N.S.
(State or country)

PARENTS

10 NAME OF FATHER Frederick J. Vincent

11 BIRTHPLACE OF FATHER (city or town) N.S.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Daley

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Frances B. O'Brien
(Address) 820 Cathedral

15 Filed ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1926, to Aug 23, 1929, that I last saw her alive on Aug 23, 1929 and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

1) Angina Pectoris

2) Pernicious Anemia

(duration) 14 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Geo. D. Rowe, M. D.

Aug 24, 1929 (Address) 1115 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	8/27/29
20 UNDERTAKER Chas. S. Brandt Son	ADDRESS 118 W. Royal

Spec.—2-29-28—L. F. S.—500 Blks.

(Venzke)

E 48783 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48783

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 6021 Bellona Ave ST. Parduna WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernil Venzke

(a) RESIDENCE NO. 6021 Bellona Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Venzke

6 DATE OF BIRTH (month, day, and year) Nov. 7th 1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country) Germany

PARENTS

10 NAME OF FATHER Emil G. Venzke

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Ida Venzke (Address) 6021 Bellona ave.

15 Filed ....., 19.... Registrar

C. HAMPSON JONES, M.D.

8 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25th 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1927, to Aug. 25 1929, that I last saw him alive on Aug. 25, 1929, and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

Carcinoma of nose

about (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. W. Bacon, M. D.

8/26, 1929 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michaels Luth. Cemetery	Aug. 28 1929

20 UNDERTAKER	ADDRESS
Frederick Lassahn & Son	Fulkstone

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48784 — CERTIFICATE OF DEATH — E 48784

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. St Joseph's Hospital, 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Hanny Hansen

(a) RESIDENCE NO. Middle River ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Hansen (Author)

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ___hrs. or ___min.
	53	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Engr Constructor Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Nellie Hansen
(Address) Middle River

15 Filed ___ 19___ ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 19 29, to Aug 22, 19 29, that I last saw h. alive on Aug 22, 19 29 and that death occurred, on the date stated above, at 9.55 P m.

The CAUSE OF DEATH* was as follows:

Acute fulminating Tuberculosis

(duration) 2 yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) 2 yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory & X-Ray

(Signed) N B Kendrick, M. D.

8/22 19 29 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Aug 26 19 29
20 UNDERTAKER John G. Connelly	ADDRESS Essex

AUG 26 1929 C. HAMPSON JONES, M. D. Registrar

Spmc.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48785 E 48785

CERTIFICATE OF DEATH

44

I—PLACE OF DEATH

CITY OF BALTIMORE (No. 223 N. Fulton Ave. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph McGee

(a) RESIDENCE NO. 223 N. Fulton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna. Mc Gee.

6 DATE OF BIRTH (month, day, and year) July 30-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant. Keeper

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McGee.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Anna. Mc Gee.

(Address) 223 N. Fulton Ave.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Aug. 26, 1929

that I last saw h.. alive on August, 1929

and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intest'l Obstruction. Hemorrhage Toxaemia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs, Phy Exam

(Signed) Bartus T. Baggott, M. D.

, 19 (Address) 1015 N. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug. 28 1929
20 UNDERTAKER John G. Connelly	ADDRESS Essex

Spec.—2-29-28—L. F. S.—500 Bks.

E 48786 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 48786

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp ST. 816 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ferdinand Smith

(a) RESIDENCE NO. 2533 E. Oliver St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Smith

6 DATE OF BIRTH (month, day, and year) Nov. 28-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pressman

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Ferdinand Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Wilmina E. Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Florence Smith

(Address) 2533 E. Oliver St.

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1929, to Aug 25, 1929, that I last saw h/m alive on Aug 25, 1929 and that death occurred, on the date stated above, at 5 15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder (Cancer)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy & growth

(Signed) Arthur Ratchnick, M. D.

8/26/1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 27 1929
20 UNDERTAKER	ADDRESS
George M. Gibbs	1737 E. Eager

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48787

CERTIFICATE OF DEATH

188-203

E 48787

1-PLACE OF DEATH

City of Baltimore: (No. Maryland Gen Hosp St., 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth R. Hayes

(a) RESIDENCE NO. 2209 John St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan-9-1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	73	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work maid
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Harry Hayes

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Ely Phillips

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant (Address) Hospital Record

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

G 26 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fract Skull
Auto in which she was riding overturned - injury her

(duration) yrs. mos. ds.

CONTRIBUTORY Fatty Emboli or Vegetation
(Secondary)
(Cardiac)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? York Rd

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) P D Strauss M. D.

8/26 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mt Cem	Aug 28 29
20 UNDERTAKER	ADDRESS
John Burns Sons	Bowie Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48788

CERTIFICATE OF DEATH.

168

E 48788

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2228 Eastern Ave. St. 1-3 Ward)

2-FULL NAME Walter . Chojnowski

(a) RESIDENCE NO. 2228 Eastern Ave. St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Sirgle

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
May 15 1894

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	35	3	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of indastry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Casimier . Chojrowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14
Informant Mrs. Marie . Miller
(Address) 2228 Estern Ave.

15 Filed_____, 19____ _____ Registrar

DKP

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 24 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide Hanging
Rope.

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) C C Slater M. D.
(Coroner)
, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Date of Burial Aug 27 1927

20 UNDERTAKER John M Weber ADDRESS 4013 Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48789

CERTIFICATE OF DEATH.

168

E 48789

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 S. Highland Ave St. 26-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emil Storch

(a) RESIDENCE NO. 222 S. Highland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Christian Storch

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Hoffm

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Christine Schoer

(Address) 222 S. Highland Ave.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Hanging
Rope
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed (Coroner) M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem. Date of Burial Aug 27 1929

20 UNDERTAKER John C. Miller ADDRESS 435 E Aliceanna St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

26 1329

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48790

101-001

E 48790

1-PLACE OF DEATH

City of BALTIMORE: (No. 318 N Bond St. Ward) 3-4

REGISTERED NO.

2-FULL NAME Frank Ulrich Jr.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 318 N Bond St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Ulrich

11 BIRTHPLACE OF FATHER (City or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Pasela

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Sophia Ulrich
(Address) 318 N. Bond St.

15 Filed 6 26 1929 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 26 29 19

17 I HEREBY CERTIFY, That I attended deceased from 6 22 29, 19 ..., to 6 26 29, 19 ...

that I last saw h... alive on 6 26 29, 19 ...

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

6. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Rosary	Aug 27 1929

20 UNDERTAKER John M Weber ADDRESS 401 S Chester Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48791

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48791

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Freed

(a) RESIDENCE NO. Preston + Valley ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Michael Freed

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Theresa Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor (Address) Preston + Valley Sts.

15 Filed 2 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 26 Aug. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 26, 1929, that I last saw h[illegible] alive on Aug 25, 1929 and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Rheumatism

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

8 26 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Aug. 28 1929

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Fremont Ave

FROM IS VERY IMPORTANT—SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48792

188-002

E 48792

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St., 10-14 Ward)

2-FULL NAME Elizabeth Farrell.

(a) RESIDENCE NO. Valley & Preston Sts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 31, 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62	4	24 23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House keeper.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Farrell.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England.

12 MAIDEN NAME OF MOTHER Mary Law.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Hospital Record.
(Address)

15 Filed ..... 19 ..... C. THOMPSON JONES, M. D. Registrar

2 C 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Femur. Accidental fall in a street car.

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gwynn Oak Park.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

8/26. 1929 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Aug 27 1929
20 UNDERTAKER	ADDRESS
Pita Wiedefeld	914 Gwynn Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48793

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48793

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes D. McGee.

(a) RESIDENCE NO. Edgemere, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of Joshua W. McGee.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Louisiana.

PARENTS

10 NAME OF FATHER Daniel J. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Mary Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Records, Baltimore City Hospitals.
(Address)

15 Filed G 27 1929 19 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to August 25, 1929, that I last saw h[er] alive on August 25, 1929 and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs mos. 5 ds.

18 Where was disease contracted if not at place of death? Private at home; Entry in hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General & anat. history.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	8/27 1929
20 UNDERTAKER Robert Lucas & Son	ADDRESS Calhoun & Hoffman

Spec.—2-29-28—L. F. S.—500 Bks.

227263

E 48794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 49

REGISTERED NO. E 48794

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James S. Ware

(a) RESIDENCE NO. Bridgeton N. J. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: V

6 DATE OF BIRTH (month, day, and year): 2-15-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: Joseph Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. J.

12 MAIDEN NAME OF MOTHER: Edith Sparlas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D. Registrar

2 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 26 1929

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to Aug-26, 1929, that I last saw h. in alive on Aug 26, 1929 and that death occurred, on the date stated above, at 11 43 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of ~~Aug~~ July 24, 29.

Was there an autopsy? Yes

What test confirmed diagnosis? Various Laboratory

(Signed) E. E. James, M. D.

8/24 19 29 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bridgeton, N. J.	Aug 26 1929
20 UNDERTAKER: Wm. J. Lubner, Jr.	ADDRESS: Knight Co

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48795

CERTIFICATE OF DEATH

117

E 48795

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland Gen'l Hospital ST., 12-1 WARD)

2—FULL NAME Ella M. Hall

(a) RESIDENCE NO. 3-West 27th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Hall

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	55	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lynchburg, Va

PARENTS

10 NAME OF FATHER Robert M. Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Lucy A. Vest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lynchburg Va.

14 Informant Hospital Record
(Address)

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1924, to Aug. 25, 1924, that I last saw h alive on Aug. 25, 1924, and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Gangrenous Appendix with local and general peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exacerbation of Carcinoma - Rectal (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug. 23, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 19...

20 UNDERTAKER Geo W. Little — ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 48796 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48796

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6118 Park Heights Ave. ST. 27-55 WARD)

REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hennie J. Daniel

(a) RESIDENCE NO. 6118 Park Heights Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Daniel

6 DATE OF BIRTH (month, day, and year) Feb. 26th. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Reuben Jandorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sallie Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. G. Daniel

(Address) New York

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26th. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 26, 1929, that I last saw h[e] alive on Aug 26, 1929 and that death occurred, on the date stated above, at 2.30 A.m.

The CAUSE OF DEATH* was as follows:

Exhaustion. (Hemiplegia)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles L. Wells M. D.

19 (Address) 5276 Park Heights Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	Aug. 27th 29

20 UNDERTAKER Ward Goodman ADDRESS 115-20 W. Mt. Royal Ave.

Cor.—10-10-29—A Co.—100 Bks.

E 48797

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48797

CERTIFICATE OF DEATH

185

1-PLACE OF DEATH

City of Baltimore: (No. Mow Mem Hospital 20 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME May Bonwit

(a) RESIDENCE NO. Marlboro 20 apts St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Bonwit

6 DATE OF BIRTH (month, day, and year) Dec. 6. 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ladies
(b) General nature of industry, business, or establishment in which employed (or employer) Apparel
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Bernhardt Bonwit

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elsie —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Sarah Bonwit
(Address) Marlborough apts

15 Filed ....., 19.... H. D. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc fall from horse.
Fracture of Skull

Duration yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? Fort Spring Valley
If not at place of death?
Did an operation precede death? No Date of Aug 27/29
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address) 1436 Kenyon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Nebo Cem. Brooklyn N. Y.	8/27 19 29
20 UNDERTAKER	ADDRESS
David Sandhuan	1118 Eutaw Pl.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48798 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48798

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH

REGISTERED NO. 1359

CITY OF BALTIMORE: (No. 2445 Lakeview ST. Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Berliner

(a) RESIDENCE NO. 2445 Lakeview ST. Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Berliner

6 DATE OF BIRTH (month, day, and year) Feb 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Levi Ehrasser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Nelson Berliner

(Address) 2445 Lakeview Ave

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

G.Z.T. 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26-29

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 26, 1929, that I last saw h[illegible] alive on Aug 26, 1929 and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchi-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) I Frederick Leitz, M. D.

8-26-1929 (Address) Temple Garden Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	8/28/1929
20 UNDERTAKER	ADDRESS
Harry Sandheim	1118 W. Fort Royal Ave

Cor.—12-9-25—A Co.—200 Bks.

E 48799

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-103

E 48799

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) St.Joseph's Hospital St. 12-50 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Jane Hodges

(a) RESIDENCE NO. 2825 St.Paul St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F.Hodges

6 DATE OF BIRTH (month, day, and year) Dec.23 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) School Teacher

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John McPherson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah J.Lyons

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Joseph Hodges

(Address) 3300 Gibbons Ave

15 Filed AUG 29 1929 HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage thrown from auto she was riding when in collision with another

(Duration) O. mos. ds.

CONTRIBUTORY (Secondary) Central Concussion

(Duration) yrs. mos. ds.

(Signed) J. J. Franc M. D.

(Coroner)

9/27 1929 (Address) 6939 Mc Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial Aug 28, 29

20 UNDERTAKER John F Denny ADDRESS 715 E. 4th

OF DEATH in plain words, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48800 129 ✓ **E 48800**

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 n Carolina ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Doan

(a) RESIDENCE NO. 509 N Carolina ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Doan

6 DATE OF BIRTH (month, day, and year) April 25 1885

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	44	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carmichael Va

PARENTS

10 NAME OF FATHER Silas Doan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nancy James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Doan

(Address) 509 N Carolina

15 Filed Aug 27 1927 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25-27

17 I HEREBY CERTIFY, That I attended deceased from May 2. 1927. to Aug 25 1927.

that I last saw him alive on Aug 25 1927

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Glomerular Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

Aug 26 1927 (Address) 508 Lamont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	Aug 29 1927
20 UNDERTAKER Mrs. R. W. Elliott	ADDRESS 1712 Eastlondon

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

48801

CERTIFICATE OF DEATH.

33 E 48801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1384 Whitmore ST., 15-23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Gray

(a) RESIDENCE NO. 1384 Whitmore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE — Years: 38 — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Ed. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Jennie Burkett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Joseph Gray
(Address): 1323 S. Eutaw

15 Filed 7-10-29 19 .. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 24 1929

17 I HEREBY CERTIFY, That I attended deceased from July 7th 1929 to Aug 24th 1929, that I last saw h- alive on Aug 23 1929, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Sutton, M. D.

19 (Address) 512 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilms Wtf Lancaster Va	Aug 27 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Pennsylvania Ave

CAUSE OF DEATH in print letters, as that it may be read in the back of certificates.

TION is very important. See instructions on back

Cor.—10-10-29—A Co.—100 Bks.

E 48802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 48802

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1526 Riggs St. 16-22 Ward)

2-FULL NAME Irena Thornton

(a) RESIDENCE NO. 1526 Riggs St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 1 mos. 20 da. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 5 1898

7 AGE — Years: 31 Months: 1 Days: 20 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Skuggs

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Emma White

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Johnson
(Address) 1526 Riggs St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

AUG 27 1929 By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage Sudden

(duration) ..... yrs.

CONTRIBUTORY (Secondary) Pulmonary Phthisis

(duration) ..... yrs. 3 mos. ..... da.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... M. D.

(Address) ..... Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Gun Cem — DATE OF BURIAL: Aug 28 1929

20 UNDERTAKER: Wm. H. Duke & Son — ADDRESS: 1400 Madison

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ~ E 48803

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 N Central Ave ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Woolman Warner

(a) RESIDENCE NO. 1209 N Central Ave ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine L. Warner

6 DATE OF BIRTH (month, day, and year) Mar 2-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Handley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catharine L. Warner

(Address) 1209 N Central Ave

15 Filed AUG 27 1929 19 H. LESTER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26-1929

17 I HEREBY CERTIFY, That I attended deceased from 8/20/29, 19, to 8/26/29, 19, that I last saw h[illegible] alive on 8/26/29 19 and that death occurred, on the date stated above, at 1:30 p m.

The CAUSE OF DEATH* was as follows:

Apoplexy

CONTRIBUTORY (Secondary) Interstitial nephritis (duration) yrs. 2 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) H. W. Gaddess, M. D.

8/27/29 19 (Address) 321 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Aug 29 1929
20 UNDERTAKER John Uelrich	ADDRESS 2008 Orleans

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48804 49 ✓ **E 48804**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-63

CITY OF BALTIMORE: (No.) 3918 W Garrison ave ST., (WARD) 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Schmeltz

(a) RESIDENCE NO. 3918 W Garrison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Schmeltz

6 DATE OF BIRTH (month, day, and year) March 2 58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Joseph Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Steiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Albert S Gates

(Address) 3918 Garrison ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 29

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1928, to Aug 25, 1929, that I last saw her alive on Aug 24, 1929, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urethra & Bladder

(duration) yrs 1 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 17/29

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) M L Gray M. D.

(Address) 622 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holly Redeemer	Aug 28 1929
20 UNDERTAKER	ADDRESS
W M Roulson	2238 W Lanvale

AUG 27 1929 THOMSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48805

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ST. 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Miller

(a) RESIDENCE NO. 513 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H Miller 1847

6 DATE OF BIRTH (month, day, and year) March 25

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Nathaniel Fletcher

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Foos

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Record

(Address) BALTIMORE CITY HOSPITALS

15 Filed Aug 27 1929 C. HAMPSON JONES, M. D. Registrar

AUG 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from 8-23, 1929, to 8-25, 1929.

That I last saw h[illegible] alive on 8-25, 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Interst

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.C. Hist.

(Signed) Marvin M McLean, M. D.

8-26 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 27 1929
20 UNDERTAKER W McKontson	ADDRESS 2301 W Lanvale

Spec.—2-29-28—L. F. S.—800 Blks.

Myers.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48806

CERTIFICATE OF DEATH

90 E 48806

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.) REGISTERED NO.

CITY OF BALTIMORE: (No. 18-16 ST. E. or W. WARD)

2—FULL NAME Lewis Meyers.

(a) RESIDENCE NO. 906 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 8 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-15-1863 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Jeremiah Meyers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Records, Baltimore City Hospitals

(Address)

15 Filed 2 7 1928, 19 [illegible] Registrar

E. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27, 1928

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1928 to August 27, 19 28, that I last saw him alive on August 24, 1928 and that death occurred on the date stated above, at 1.30 A m.

The CAUSE OF DEATH was as follows:

Hemorrhage into cerebrum

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; hypertension; Chronic myocarditis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient in Hospital. Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Marvin M. McLean M. D.

. 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — DATE OF BURIAL 8-7-28 19

20 UNDERTAKER George D. Pentz & Son — ADDRESS 1735 Harford Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48807

CERTIFICATE OF DEATH

49 E 48807

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 E. 22nd ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patrick J. Gannon

(a) RESIDENCE NO. 416 E 22nd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if foreign birth 59 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

a If married, widowed or divorced HUSBAND of (or) WIFE of Marie E Gannon

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James P. Gannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Marie E Gannon

(Address) 416 E 22nd St.

15 Filed Aug 27 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1929

17

I HEREBY CERTIFY, That I attended deceased from March, 1929, to Aug. 26, 1929, that I last saw h in alive on Aug 26 1929 and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Sarcomatosis

(duration) yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Sarcoma of neck

(duration) yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J. Mullen, M. D.

8/29, 1929 (Address) 532 E 22nd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 29 1929
20 UNDERTAKER Henry Hoeck Sons Inc.	ADDRESS [redacted]

Spec.—2-29-28—L. F. S.—500 Blks.

Stopper · Dr Richard 33 N + 41 Paul St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48808

CERTIFICATE OF DEATH

129

E 48808

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6151 Maurietta ST., 17-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Magdalen A. Stopper

(a) RESIDENCE NO. 6151 Maurietta ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Stopper

6 DATE OF BIRTH (month, day, and year) April 16 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER John T. Chesmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm J. Stopper

(Address) 6151 Maurietta Ave

15 Filed ....., 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, to Aug 25, 29

that I last saw her alive on Aug 29, 29

and that death occurred, on the date stated above, at 4 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) One yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Raymond M. D.

6, 29 (Address) 2612 Reed

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 8 28 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

E 48809

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48809

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 3403 Frankley Ave. Ward) 215-62 D4-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David H. Drohan

(a) RESIDENCE NO. 3403 Frankley Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen. Drohan

6 DATE OF BIRTH (month, day, and year) June 5-1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	2	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER David Drohan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Roache

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Helen Drohan
(Address) 3403 Frankley Ave

15 Filed ..... 19 ..... PALMER A. JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) ..... yrs. ..... mos. Hours

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Coroner, M. D.

Aug 28/29 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Aug 28 1929
20 UNDERTAKER William Cook	ADDRESS 1217 St Paul Street

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48810 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23 E 48810

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Rippberger

(a) RESIDENCE NO. 1220 Linden Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 6 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25. 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	6 8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Hosp

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country) md

PARENTS

10 NAME OF FATHER Conrad Rippberger

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) U. S
(State or country) unknown

14

Informant Josephine Rippberger

(Address) Plumb Lyn. Md

15

Filed ....., 19.... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929, to Aug 26, 1929, that I last saw he alive on Aug 26, 1929 and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(or Bronchial Pneumonia) (duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Balt md

Did an operation precede death? No Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Jesse L Taylor, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	8/29 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 E Pratt

Spec.—2-29-28—L. F. S.—500 Blks.

E 48811 HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Darned 1327 Park ave

E 48811

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2001 Kennedy ave ST., 5-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clementine Carter

(a) RESIDENCE NO. 2001 Kennedy ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dunus Carter

6 DATE OF BIRTH (month, day, and year) Aug 16, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	58		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Frederick Maryland

PARENTS

10 NAME OF FATHER George A Abbott

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Maryland

12 MAIDEN NAME OF MOTHER Clementine Burrucker

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Maryland

14 Informant Mrs. Dunus Carter

(Address) 2001 Kennedy Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1925 to Aug 26, 1929

that I last saw her alive on Aug 25-1, 1929

and that death occurred, on the date stated above, at 5 A/ m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory —

(Signed) Chas W Lamond M. D.

Aug 27, 1929 (Address) 137 Park Ave Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Frederick Md	Aug 29 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48812

CERTIFICATE OF DEATH

90 E 48812

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 3-5 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Votta.

(a) RESIDENCE NO. 307 S. Hugh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Michael Votta.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Anthony Schiavo.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Forio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Records
(Address) Baltimore City Hospitals.

15 Filed Aug 27, 1929 H. HANSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1929, to Aug 24, 1929, that I last saw h.. alive on August 24, 1929 and that death occurred, on the date stated above, at 4:52 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Myocarditis. Chronic

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Exam.

(Signed) Marvin M. McEwan, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Aug 28, 1929.

20 UNDERTAKER Wendell J. Krapf ADDRESS 211 S. Edmondson

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48813

CERTIFICATE OF DEATH.

E 48813

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 Otterbein ST. 21-29 WARD)

2-FULL NAME James Bailey

(a) RESIDENCE NO. 218 Otterbein ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Bailey

6 DATE OF BIRTH (month, day, and year) ——— 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Clover Virginia

PARENTS

10 NAME OF FATHER Booker Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Clover Virginia

12 MAIDEN NAME OF MOTHER Laura Moseley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Clover Virginia

14 Informant Jessie Bailey
(Address) 431 Druid Hill Ave

15 Filed AUG 27 1929 19 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/10 1929, to 8/26 1929, that I last saw him alive on 8/25 1929, and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
Hypertension

(duration) yrs. "4" mos " ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Walter Reed Hosp

(Signed) Dan C. Jones M. D.

8/27 1929 (Address) 122 N Sec St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Aug 29, 1929
20 UNDERTAKER	ADDRESS 722
Mrs Kate R. Williams	1 Schroeder St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 48814

CERTIFICATE OF DEATH

E 48814

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 17-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernestine Shemhock

(a) RESIDENCE NO. 872 [redacted] Pierce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Daniel Shemhock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md

12 MAIDEN NAME OF MOTHER Lillie Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Daniel Shemhock

(Address) 872 Pierce st.

15 Filed AUG 27 1929 G. W. Booth Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to Aug 24, 1929, that I last saw HER alive on Aug 24, 1929, and that death occurred, on the date stated above, at 7:05 P m.

The CAUSE OF DEATH* was as follows:

Pericardial effusion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 27, 1929 Thoracotomy

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. D. Kenagey, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natore of Injory, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Aug. 27, 1929
20 UNDERTAKER	ADDRESS 322 N.
Mrs. Katie R. Williams	Schroeder St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48815

74-001

E 48815

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1437 Marshall ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Meekins

(a) RESIDENCE NO. 1437 Marshall ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Ella Meekins

6 DATE OF BIRTH (month, day, and year) Aug 14 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Capt of Boat

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ethridge Meekins

(Address) 1738 N. Post St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Aug 25, 1929, that I last saw him alive on Aug 25, 1929, and that death occurred, on the date stated above, at 7.25 p.m.

The CAUSE OF DEATH* was as follows:

Paralytic Hemorrhage of Brain

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Hardening of Arteries & High Blood Pressure (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Bacon, M. D.

8/26 1929 (Address) 3907 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Aug 28 1929
20 UNDERTAKER Philip Stenig	ADDRESS 2016 Edmondson Ave

AUG 27 1929 HARRY JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48816 129 E 48816

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 725 N. Lakewood Ave. ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Schlimm

(a) RESIDENCE NO. 725 N. Lakewood Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Schlimm

6 DATE OF BIRTH (month, day, and year) June 6/1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Island Export

(c) Name of employer Oil Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Schlimm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret-------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Francis Schlimm

(Address) 725 N. Lakewood Ave.

15 Filed (, 19) ( ) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24/29

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to aug 24, 1929, that I last saw h[illegible] alive on aug 24, 1929 and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia
cardio - vascular - renal
(2 yr.).

CONTRIBUTORY (Secondary) Arterial hypertension - Enlarged [illegible] (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine - gen. exam -

(Signed) Louis F. Krumeich, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem. DATE OF BURIAL Aug. 28/29

20 UNDERTAKER Philip Henrig ADDRESS 2016 Orleans St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48817

CERTIFICATE OF DEATH.

91-002

E 48817

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4001 (ST.) Hamilton Ave (WARD) 27-42

2-FULL NAME Albert Edward Walden.

(a) RESIDENCE NO. 4001 Hamilton Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or wife of~~ Jessie V. Walden

6 DATE OF BIRTH (month, day, and year) Aug 26 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Consulting Engr.

(b) General nature of Industry, business, or establishment in which employed (or employer) 036

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Edward Harris Walden

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Elva Packard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant (Address) Jessie V. Walden Tuxedo Hamilton Ave

15 Filed AUG 27 1929, 19 M. C. PARRAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to Aug 26, 1929, that I last saw him alive on Aug 26, 1929, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Previous (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cumbaa, M. D.

Aug 26, 1929 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Park Wood Cemetery — DATE OF BURIAL Aug 29 1929

20 UNDERTAKER Joseph Sy per — ADDRESS 1600 N. North Ave

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 48818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48818

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2604 Hudson St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter (Victor) Oles

(a) RESIDENCE NO. 2604 Hudson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. da. How long in U. S. if of foreign birth? 50 yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Antonina Oles

6 DATE OF BIRTH (month, day, and year): Dec. 1 1875

7 AGE: Years 53 Months 8 Days 25 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Poland

(State or country)

PARENTS

10 NAME OF FATHER: Anthony Oles.

11 BIRTHPLACE OF FATHER (City or town): Poland.

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): Poland.

(State or country)

14 Informant: Antonina Oles.

(Address) 2604 Hudson

15 Filed ____ 19____ ____, Registrar

AUG 27 1929 C. HAMILTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929 Aug 26

17 I HEREBY CERTIFY, That I attended deceased from 8-25- 1929 to 8-26- 1929

that I last saw him alive on 8-26- 1929

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ____ yrs. ____ mos. 5 da.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ____ yrs. ____ mos. 1/2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Physical Signs

(Signed) I. F. Bronushas. M. D.

8-27. 1929 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. — Date of Burial: aug 29 1929

20 UNDERTAKER: Stephen J. Fialkowski Inc — ADDRESS: 1002 Hennen Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48819 — **CERTIFICATE OF DEATH** — **E 48819**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Univ Hosp St., W-30 Ward)

2-FULL NAME Herman D. Weigold

(a) RESIDENCE NO. 141 Riverside Av Torrington Conn St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elsa Weigold

6 DATE OF BIRTH (month, day, and year) dont know

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Game Warden
(b) General nature of industry, business, or establishment in which employed (or employer) State Fisheries
(c) Name of employer State of Conn 086

9 BIRTHPLACE (city or town) .....
(State or country) Torrington Conn

PARENTS

10 NAME OF FATHER Louis Weigold

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Rudolstadt Germ

12 MAIDEN NAME OF MOTHER Lucy Drake

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Sharon Conn

14 Informant Mrs. Elerson
(Address) Torrington Conn

15 Filed 2 7 1929 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull (com comp) Fract L. for
Fract L. Ilium & Ischia (Both) Head on collision
between auto he was driving and bus

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Central Compression

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Trask Rd at Dorsey Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. D. Frame M. D.

8 27 1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Torrington, Conn.	Aug 27 1929
20 UNDERTAKER Joseph D Cook	ADDRESS 1003 N Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48820

CERTIFICATE OF DEATH

E 48820

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-25 Ward) 192

2-FULL NAME Daurl I. Comegys

(a) RESIDENCE NO. 641 W. Mulbrry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2a yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Marrd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Comegys

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pa.

PARENTS

10 NAME OF FATHER John W. Comegys

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Laura Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Laura Jackson
(Address) 641 W. Mulberry St

15 Filed 8-27 1929 19 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Revolver wound of abdomen. Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 641 W. Mulberry St

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edgar Zeller M. D.

8/26. 1929. (Address) 239 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Pleasant Cem

DATE OF BURIAL 8-28 1929

20 UNDERTAKER Clarence C. Wright

ADDRESS 1424 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48821

CERTIFICATE OF DEATH

31 E 48821

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wesley Ames

(a) RESIDENCE NO. 1226 Lafayette ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Tom Ames

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Florence Barton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed 9 7 1929, 19 C. HAMPSON JONES, M. D.
Per RCH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 9, 19 29, to August 26, 19 29,
that I last saw him alive on August 26, 19 29
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Jos. Arnold Jr., M. D.

8-26, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cem	8-29 1929
UNDERTAKER	ADDRESS
Clarence L. Wright	1369 N. Carey St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48822

CERTIFICATE OF DEATH

161-201

E 48822

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bx Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Smith

(a) RESIDENCE NO. Westminster Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph W. Smith

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Hilda Melgaun

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Joseph W. Smith
(Address) Westminster Md.

15 Filed 2 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/29

17

I HEREBY CERTIFY, That I attended deceased from 8/27, 1929, to 8/27, 1929, that I last saw her alive on 8/27, 1929, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thomas Reese, M. D.

19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Cemetary	8/28/29
20 UNDERTAKER L. Francis Reese	ADDRESS Westminster Md.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 48823

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 27-56 (WARD)
Caroline + Oliver Sts

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Kessler

(a) RESIDENCE NO. 4820 Pimlico Rd. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Kessler

6 DATE OF BIRTH (month, day, and year) unknown 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) U Railway Elect Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Minsodo

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Minsodo

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Minsodo

14 Informant Mrs Gertrude Kessler
(Address) 4820 Pimlico Rd

15 Filed 2 7 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-29

17

I HEREBY CERTIFY, That I attended deceased from 8-20, 1929, to 8-26, 1929, that I last saw h.m. alive on 8-26, 1929 and that death occurred, on the date stated above, at 12-20 a.m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix
Peritonitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? Yes Date of 8-20-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M B Hundley, M. D.

8/26-29 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Cemetery

DATE OF BURIAL [illegible]

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins Sts

Spec.—2-29-28—L. F. S.—500 Bks.

St Paul 626 N. Gilmor St

HEALTH DEPARTMENT—CITY OF BALTIMORE.

Dulay 90

E 48824

CERTIFICATE OF DEATH

E 48824

1—PLACE OF DEATH

REGISTERED NO. 20-28

CITY OF BALTIMORE: (No. 1911 W. Balto ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John C. Daley or Daley

(a) RESIDENCE NO. 191 W Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 10 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah L. Daley

6 DATE OF BIRTH (month, day, and year) July 14th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Daley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas. L. Gilbert

(Address) 191 W. Balto St

15 Filed 2 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 29

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Aug 26, 1929, that I last saw him alive on Aug 24, 1929 and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) M Bamandouler, M. D.

8/27, 1929 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westview Cemetery	Aug 28th 1929
20 UNDERTAKER	ADDRESS
F. C. Nuthut	853 W. Balto St

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48825

CERTIFICATE OF DEATH

90 E 48825

1—PLACE OF DEATH

REGISTERED NO. 25-15

CITY OF BALTIMORE: (No. 1732 Chesapeake Ave ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur R. Hansen

(a) RESIDENCE NO. 1732 Chesapeake ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elfrieda Hansen

6 DATE OF BIRTH (month, day, and year) March 13-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work SS Captain do

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Gustave Hansen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Hansen (Wife)
(Address) 1732 Chesapeake Ave

15 Filed 2 7 1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Aug 27, 1929, that I last saw him alive on Aug 24, 1929, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiac Disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation 30 min

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frederick R. Ward, M. D.

8/27, 1929 (Address) 527 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Aug. 30 1929
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1422 Light St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48826

E 48826

1—PLACE OF DEATH Balto City Hospt 38

CITY OF BALTIMORE: (No. Balto Md. ST. 1-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Nichols

(a) RESIDENCE NO. 1615 E. Madison St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 8

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) Balt City Hospt

15 Filed ....., 19 C. HAMPSON JONES, M. D. 8 29 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25-29

17 I HEREBY CERTIFY, That I attended deceased from 8-30, 19 29 to 8-25, 19 29 that I last saw him alive on 8-25, 19 29 and that death occurred, on the date stated above, at 10.45 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical & Clinical findings

(Signed) Thos H Donnelly M. D.

8/31, 19 29 (Address) Bittner Ct & Hilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Crem

DATE OF BURIAL 8-28 1929

20 UNDERTAKER Byrnes & Wright 1218 McCulloh St

ADDRESS

Spec.—2-29-28—L. F. S.—860 Bks.

Dr Magruder, 1206 E. Preston St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48827

CERTIFICATE OF DEATH

E 48827

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 614 E. 29th ST., 9-44a WARD)

2—FULL NAME Gilbert F. McConley

(a) RESIDENCE NO. 614 E 29th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Gilbert McConley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ellen Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Ellen McConley
(Address) 614 E 29th St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27. 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/22, 1929, to 8/27, 1929, that I last saw him alive on 8/26, 1929, and that death occurred, on the date stated above, at 9:05 A m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) ... yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Pennington Gross, M. D.

8/27, 1929 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cathedral — DATE OF BURIAL: 8/28/1929

20 UNDERTAKER: J. M. Cook — ADDRESS: 1217 E. Oldtown

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48828

CERTIFICATE OF DEATH

90

E 48828

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 16-68 WARD)

2—FULL NAME Annie Mulkay

(a) RESIDENCE NO. 2808 Freeman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	? Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Mulkay

6 DATE OF BIRTH (month, day, and year) ? 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Philadelphia

9 BIRTHPLACE (city or town) ?
(State or country) Pa.

PARENTS

10 NAME OF FATHER David Mulkay

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Ellen ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Pa.

14 Informant Record
(Address) BALTIMORE CITY HOSPITALS

15 Filed 2 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27-29

17

I HEREBY CERTIFY, That I attended deceased from 6-25, 1929, to 8-27, 1929

that I last saw him alive on 8-27, 1929

and that death occurred, on the date stated above, at 1 45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. C.P.

(Signed) Marvin M McLean, M. D.

8-27, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	8 29 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Fond St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48829

CERTIFICATE OF DEATH

129

REGISTERED NO. E 48829

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH 409 N. Lee St.

CITY OF BALTIMORE: (No. 1 ST. 1720 WARD)

2—FULL NAME Maud Freeman

(a) RESIDENCE NO. 409 N Lee ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Freeman

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Geo Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

11 Informant Alexander Freeman

(Address) 630 N Lee St.

15 Filed AUG 28 1929 H. L. MOSHER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Aug 26, 1929

that I last saw he alive on Aug 26, 1929

and that death occurred, on the date stated above, at 6.40 P.m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

CONTRIBUTORY (Secondary) Uremia (duration) yrs. 1 mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no What test confirmed diagnosis? Physical

(Signed) H. J Tompkins M. D.

19 (Address) 5 W Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Aug 29, 1929
20 UNDERTAKER John H. Frazier	ADDRESS 1027 Hanover

Spec.—2-29-28—L. F. S.—500 Bks.

E 48830

HEALTH DEPARTMENT—CITY OF BALTIMORE

54-003

E 48830

CERTIFICATE OF DEATH

1—PLACE OF DEATH Univ. Hosp.

CITY OF BALTIMORE: (No. Baltimore St. 4-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peggy Ann Holden

(a) RESIDENCE NO. 3633 Hamilton St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white.

5 Single, Married, Widowed, or Divorced (write the word): baby.

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 31, 1929.

7 AGE — Years: — Months: — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Univ. Hosp. Balto. Md.

PARENTS

10 NAME OF FATHER: F. A. Holden M.D.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Queen Annes Co. Md.

12 MAIDEN NAME OF MOTHER: Gladys M. Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Dr. F. A. Holden

(Address): 3633 Hamilton St.

15 Filed: [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/27/ 1929 to 8/28 1929 that I last saw her alive on 8/28 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Obstructed Obstruction.

Pneumonia.

Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Pyloric Stenosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Holden M. D.

Aug. 29 1929 (Address) Medical Art Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem.

DATE OF BURIAL: Aug. 28 1929

20 UNDERTAKER: Albert S. Little

ADDRESS: 2706 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 48831

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48831

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 10108

CITY OF BALTIMORE: (No. 1434 N. Bond ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Barbour

(a) RESIDENCE NO. 1434 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? Life mos. ds.

(If non-resident give city, town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs Laura V. Barbour

6 DATE OF BIRTH (month, day, and year) Jan. 13 1874

7 AGE: Years 55 | Months 7 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md

PARENTS

10 NAME OF FATHER: Zebulon T. Barbour

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Md

12 MAIDEN NAME OF MOTHER: Delilah Barbour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md

14 Informant: Mrs Laura V. Barbour

(Address) 1434 N. Bond St

15 Filed AUG 28 1929 J. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/20/ 1929 to 8/26/ 1929

that I last saw him alive on 8/26/29 at 4.15 P. m.

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Pyo-nephrosis - (both Kidneys)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pneumonia - Rt upper lobe -

(duration) yrs mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No - Date of

Was there an autopsy? no -

What test confirmed diagnosis? Myalgia + physical

(Signed) George Abner Bowden M. D.

8/27/ 1929 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mass Cemetery Parkville Md.

DATE OF BURIAL: Aug 28 1929

20 UNDERTAKER: Henry Koeck Sons Inc

ADDRESS: 301 E Eager St

Spec.—1-12-23—M&T—500 Bks.

E 48832 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48832

CERTIFICATE OF DEATH.

52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 526 W. Lee st. (St.) 27-30 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Dennis

(a) RESIDENCE NO. 526 W. Lee ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Byrd Dennis (Address) 526 W Lee St

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

AUG 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/25 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1929, to Aug 25, 1929

that I last saw h alive on 8/25, 1929

and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) acute cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Muller, M. D.

, 19 (Address) 2030 Wilkens ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Aug 28, 1929

20 UNDERTAKER Samuel Bensley ADDRESS W Balto

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

E 48833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 48833

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 10-16 ST. ... WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora Watts

(a) RESIDENCE NO. 117 N. Carey ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Watts

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Md.

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bostick

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md.

14 Informant (Records of
(Address) BALTIMORE CITY HOSPITALS

FILED AUG 28 1929, 19 C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25-29

17 I HEREBY CERTIFY, That I attended deceased from 8-6, 1929, to 8-25 1929,

that I last saw her alive on 8-25, 1929

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastasis

Myocarditis, Chronic & acute (2 yrs.)

Tbc. ?? of lung

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Cardiac

Cachexia, of lung (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & Clinical Lab Tray

(Signed) Warren H. McLean, M. D.

8-26 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL Aug 28 1929

20 UNDERTAKER Samuel Hensley

ADDRESS 57 Eutaw

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48834

CERTIFICATE OF DEATH

90

E 48834

REGISTERED NO.

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 14-20 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Jones

(a) RESIDENCE NO. 1416 Myrtle Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jones ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? Odd

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Va.

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER Vannie Russell

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant Records
(Address) BALTIMORE CITY HOSPITALS

15 Filed AUG 28 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25-29

17

I HEREBY CERTIFY, That I attended deceased from 7-9, 1929, to 8-25, 1929,

that I last saw h.. alive on 8-25, 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Jacute

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an aperation preceda death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy, Hist. E. Lab Exam

(Signed) Marvin M. McLean, M. D.

8-26 1929 (Address) ALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Aug 28 1929
20 UNDERTAKER Thomas E. Kelson.	ADDRESS 1803 Pressman St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48835

CERTIFICATE OF DEATH

E 48835

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp. 11-24 Ward)

2-FULL NAME Jas. E. Gardner.

(a) RESIDENCE NO. Glen Morris Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V.

6 DATE OF BIRTH (month, day and year) Apr 3-1890

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Penna

9 BIRTHPLACE (city or town) Penna
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mary V. Gardner
(Address) Reisterstown

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows: (Accident)
Fractured Skull
(Duration) yrs. mos.
CONTRIBUTORY (Secondary) fell off Scaffold in Shut Mill.
(Duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Glen Morris
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible] M. D.
Aug 28 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashburton M. E. Cemetery	Aug 30 1924
20 UNDERTAKER H. Reisterstown	ADDRESS
H. F. Colvin Reisterstown Md	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occ... important. See instructions on back of certificate.

AUG 28 1924 C. HARRISON JOHNSTON

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48836

113 E 48836

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2708 Odonnell St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine H. Hoyt

(a) **RESIDENCE NO.** 2708 Odonnell St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 4 1929

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Hoyt

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country) Md

12 MAIDEN NAME OF MOTHER Anna Krodman

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Frank Hoyt

(Address) 2708 Odonnell st.

15 Filed ... 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Aug 27, 1929, that I last saw her alive on Aug 26, 1929 and that death occurred, on the date stated above, at 730 A. m.

The CAUSE OF DEATH* was as follows:

enteric colitis acute

(cholera infantum)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 1 hr

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. W. Wright M. D.

8/27/1929 (Address) 1014 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Sacred Heart Cem	Aug 28 1929
20 UNDERTAKER	**ADDRESS**
Stephen J. Fialkowski Inc.	1000 S Kenwood Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

48837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

162 E 48837

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hosp ST. Dix Ave WARD 6)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Gerlach

(a) RESIDENCE NO. 1919 Cedrick Pl. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Howard Gerlach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Charolia Duncan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Hospital Record.
(Address)

15 Filed [illegible] 1929 HUGH A. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25-29

17

I HEREBY CERTIFY, That I attended deceased from 8-25-29, 19..., to 8-25-29, 19...,

that I last saw him alive on 8-25-29, 19...,

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Asphyxiation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

8/26, 19 29 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hospital	19
20 UNDERTAKER	ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-002

E 48838

REGISTERED NO.

1—PLACE OF DEATH St Joseph Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 9-18 WARD)

2—FULL NAME Patrick A. Bowes

(a) RESIDENCE NO. 738 E Preston ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary A. Bowes

6 DATE OF BIRTH (month, day, and year) Mar. 7- 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Patrick Bowes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Whalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary A. Bowes

(Address) 738 E. Preston St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1929 to Aug 26, 1929

that I last saw h.. alive on Aug 26, 1929

and that death occurred, on the date stated above, at 9 50 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

Left Side

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. H. Barkanco, M. D.

19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem. Govans	Aug 30 1929

20 UNDERTAKER Chas. S. Ward & Son ADDRESS 1186 Edmondson Ave

AUG 28 1929 HAMPSON JONES M F

Spec.—2-29-28—L. F. S.—500 Blks.

E 48839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 48839

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Philip Madera

(a) RESIDENCE NO. Frostburg - Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Dick Madera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Donatro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 27-29

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1929, to August 27, 1929, that I last saw h[illegible] alive on August 27, 1929, and that death occurred, on the date stated above, at 4.35 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Glioma (Malignant)

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Frostburg Md.

Did an operation precede death? Yes Date of 8/27/29

Was there an autopsy? Yes

What test confirmed diagnosis? Surgery & Autopsy

(Signed) Clarence C Gardner Jr. M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md — DATE OF BURIAL 8/28/29

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48840 ✓ E 48840

E 48840

CERTIFICATE OF DEATH

199

1-PLACE OF DEATH

City of Baltimore: (No. St Joseph Hospital St., 8-45 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Melocik

(a) RESIDENCE NO. 3441 Harwell Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Adam Melocik

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Soul

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Adam Melocik (son)
(Address) 735 N. Kenwood Ave

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

AUG 28 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage due to
Fractured Skull
(Homicide)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? yes Date of Aug 27/29

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H. H. Peters, M. D.

19 8/26/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 29 1929
20 UNDERTAKER Grant & Brack Sons 1906	ADDRESS Edmondson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

48841

HEALTH DEPARTMENT—CITY OF BALTIMORE

139 V

CERTIFICATE OF DEATH

E 48841

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1051 W Lexington ST. 18-16 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Downs.

(a) RESIDENCE NO. 1051 W. Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Downs

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: About, 50 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress. Out

(b) General nature of industry, business, or establishment in which employed (or employer): Laundry Work

(c) Name of employer: Harry Rheling, Mont Kaufer

9 BIRTHPLACE (city or town) (State or country): Dont Know

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. K.

12 MAIDEN NAME OF MOTHER: U. K.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. K.

14 Informant: Ethel Hall (Nurse)

(Address) 12 N Carrollton Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/25/29.

17

I HEREBY CERTIFY, That I attended deceased from Aug. 18th, 1929, to Aug. 25th, 1929, that I last saw h[illegible] alive on Aug. 25. 1929, and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows: Septic Peritonitis

CONTRIBUTORY (Secondary) Fibroid Tumor (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? at the home (duration) 5 yrs. 2 mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) J. S. Downs, M. D.

8/27 1929 (Address) 622 N. Carlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Aug 28, 1929

20 UNDERTAKER: Mrs Hester R. W Means — ADDRESS 322 N. Schroeder St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48842

CERTIFICATE OF DEATH.

44 E 48842

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1607 Elmtree ST. 25577 (WARD)

2-FULL NAME Antoni Petroska-

(a) RESIDENCE NO. 1607 Elmtree ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. ? 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	65	11	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith -

(b) General nature of industry, business, or establishment in which employed (or employer) Helper

(c) Name of employer Balto. Car Works -

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER George Petroska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) Geo. Petroska 1607 Elmtree St. D.

15 Filed AUG 20 1863 19 C. HAMPSON WORTHINGTON, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1929

17

I HEREBY CERTIFY, That I attended deceased from June 19 29 to Aug. 26 19 29.

that I last saw him alive on Aug. 25 19 29.

and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings-X-ray

(Signed) A. V. Bruchanski M. D.

8/27 19 29 (Address) 37 S Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Cross a.a. aug 29 1929

20 UNDERTAKER — ADDRESS

John Gobbiancheski 423 S Pac

CAUSE OF DEATH must be stated for every death, no matter how long or short the attendance. See instructions on back of certificates.

TION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

164001

E 48843

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 S. Paca St ST. 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Gerve

(a) RESIDENCE NO. 530 S. Paca St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-27-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				30 m.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Simon Gerve

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Elizabeth Brangaichiute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Mrs. Elizabeth Gerve

(Address) 530 S. Paca St

15 Filed 8-29-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-28-29

17 I HEREBY CERTIFY, That I attended deceased from 8-27- , 19 29, to 8-28- , 19 29, that I last saw him alive on 8-27- , 19 29, and that death occurred, on the date stated above, at 12:15 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis neonatorum

(duration) yrs. mns. ds.

CONTRIBUTORY (Secondary) Premature at 6 1/2 months

(duratinn) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) I. B. Bronushas, M. D. M. D.

8-28- , 19 29 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: aug 28 1929

20 UNDERTAKER: John Grebliauckas — ADDRESS: 4238 Paca St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48844
1—PLACE OF DEATH

CERTIFICATE OF DEATH

90

E 48844
REGISTERED NO.

CITY OF BALTIMORE: (No. 3221 Pleet ST., 26-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Sammuette

(a) RESIDENCE NO. 3221 Pleet ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widnwed, or divorced
HUSBAND of
(or) WIFE of the late Robert Sammuette

6 DATE OF BIRTH (month, day, and year) [illegible] 1855

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
74	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Badum

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14
Informant Catherine Kerchner
(Address) 221 West St

15
Filed....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26th 29

17
I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1929, to Aug. 26, 1929, that I last saw her alive on Aug. 26, 1929, and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:
Chronic Mitral Insufficiency

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Jaundice adema of Lungs

..... (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry B. Atlee, M. D.

8/27, 1929 (Address) 2504 E. Pleet St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	Aug. 28 19

20 UNDERTAKER [illegible]
ADDRESS 4008 Wash Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48845

CERTIFICATE OF DEATH

144

REGISTERED No. E 48845

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 N. Earley ST., 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothy Noelle

(a) RESIDENCE NO. 138 N. Earley ST. 6 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Noelle

6 DATE OF BIRTH (month, day, and year) Nov. 6 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	32	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Bernard Strobleder

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Maria Lerch

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Albert Noelle

(Address) 138 N. Earley St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Aug 27, 1929 that I last saw her alive on Aug 27, 1929 and that death occurred, on the date stated above, at 6 45 a. m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage after birth of child 1 hour

(Duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Uterine retention 1 hr

(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) V. H. Duker M. D.

(Address) 928 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug. 31 1929
20 UNDERTAKER	ADDRESS
Lilly & Gilden Inc	[illegible]

G 25 1929 H. M. JAMES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 1-~~48846~~ DEATH

90

E 48846

REGISTERED NO.

CITY OF BALTIMORE: (No. 38 S. Eden ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon Austerlitz

(a) RESIDENCE NO. 38 S. Eden St. ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? 10 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Frieda Austerlitz

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) as above

(c) Name of employer himself

9 BIRTHPLACE (city or town) (State or country) Warsaw-Poland

PARENTS

10 NAME OF FATHER Isaac Austerlitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Austerlitz

(Address) 1001 E. Broadway

15 Filed AUG 29 1929 ~~Registrar~~ [illegible] M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 7th, 1929, to Aug 28, 1929, that I last saw him alive on Aug 28th, 1929 and that death occurred, on the date stated above, at 10 20 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy, (Hemorrhage)
(Cerebral thrombosis)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of?

Was there an autopsy? No

What test confirmed diagnosis? hemiplegia

(Signed) B. Rushwin, M. D.

Aug 28, 1929 (Address) 1804 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wehrenberg Bros Funeral Home DATE OF BURIAL 8/28/1929

20 UNDERTAKER Jack Lewis ADDRESS 1432 E. Balto St

Spec.—2-29-28—L. F. S.—500 Blks.

E 48847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48847

1—PLACE OF DEATH Baltimore City Hospitals. REGISTERED NO.

CITY OF BALTIMORE: (No. 18-7a ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Bowen

(a) RESIDENCE NO. 939 SarahAnn St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bowen

6 DATE OF BIRTH (month, day, and year) ? 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Va. ?

PARENTS

10 NAME OF FATHER Geo. Bowen

11 BIRTHPLACE OF FATHER (city or town) Va. ?
(State or country)

12 MAIDEN NAME OF MOTHER Winnie ?

13 BIRTHPLACE OF MOTHER (city or town) Va. ?
(State or country)

14 Informant Records of Balto. City Hosp
(Address)

15 Filed AUG 28 1929 H. A. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27-29

17 I HEREBY CERTIFY, That I attended deceased from August 23, 1929, to August 27, 1929, that I last saw him alive on August 27, 1929, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Fatal, c
insufficiency & arteriosclerosis

(duration) yrs. over 21 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Not Dx

(Signed) Harris M. McClean, M. D.

8-28, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. Mclenborn	8-28 1929
20 UNDERTAKER Lewis Easton	ADDRESS 916 Eutaw

Spec.—2-29-28—L. F. S.—500 Blks.

E 48848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 48848

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 606 W Mulberry ST. (WARD) 17 26

2—FULL NAME Perry Myers.

(a) RESIDENCE NO. 606 W Mulberry St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) Pupil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Peter Myers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Lewis.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Minnie Myers.
(Address) 606 Mulberry St.

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/27

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1927, to Aug 28, 1927, that I last saw him alive on Aug 26, 1927, and that death occurred, on the date stated above, at 7.45 A.M. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes What test confirmed diagnosis? Clinical & Laboratory

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 165 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 8-29 1927

20 UNDERTAKER Dennis Curtin

ADDRESS 716 N

Spec.—1-10-21—M&T—1500 Bks.

Brooks ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48849

CERTIFICATE OF DEATH.

31 E 48849

REGISTERED NO.

1-PLACE OF DEATH United States Marine Hospital, Baltimore, Maryland.

CITY OF BALTIMORE: (No. 48-76 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Brooks

(a) RESIDENCE NO. 839 Vine Street, Balto., Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	40	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Brooks (dead)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary E. Nelson

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant U. S. Marine Hospital (records)
(Address) Baltimore, Maryland.

15 Filed AUG 29 1929, 19 C. HAMILTON ELLIS M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1929

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to August 27, 1929,

that I last saw him alive on August 27, 1929,

and that death occurred, on the date stated above, at 4:20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) unknown yrs. mos de.

CONTRIBUTORY (Secondary) Lung abscess

(duration) yrs. 1-½ mos. de.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical examination & X-Ray

(Signed) Ralph L. Porter M. D.

8-27 1929 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL 8-29-1929

20 UNDERTAKER Daniel Eichorn

ADDRESS 716 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48850

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48850

113

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 528 S. Bond ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kamil Plona

(a) RESIDENCE NO. 528 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27-28

7 AGE: Years | Months: 10 | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Antoni Plona

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Bertha Boskowska.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Antonj Plona

(Address) 528 S. Bond St

15 Filed 2 9 1929 19 H. AMPSON COOPER, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 29

17

I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1929, to Aug 27, 1929.

that I last saw him alive on Aug. 27, 1929

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) History 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Libby M. D.

19 (Address) 1-3 S. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Aug 29 1929
20 UNDERTAKER	ADDRESS
J W Ozazewski	1930 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48851

CERTIFICATE OF DEATH

90 ~ E 48851

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 N Monument ST., 6-10 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Riley

(a) RESIDENCE NO. 807 N Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	B	M

a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Riley

6 DATE OF BIRTH (month, day, and year) Oct 15 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	57	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Victoria Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Clarence Riley

(Address) 1508 E. Hamilton

15 Filed AUG 29 1929 H. JAMES JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 - 29

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 25, 1929, that I last saw h[illegible] alive on July 25, 1929 and that death occurred, on the date stated above, at 1105 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) Wm Pall, M. D.

July 26, 1929 (Address) 508 [illegible] St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 8-29 1929

20 UNDERTAKER Byron Wright 1218 Mc & Elderry St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 48852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48852

1—PLACE OF DEATH Baltimore City Hospitals. REGISTERED NO. 16-26

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Jones

(a) RESIDENCE NO. 609 Carrollton Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): ?

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Va. ?

PARENTS

10 NAME OF FATHER: Cornelius Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va. ?

12 MAIDEN NAME OF MOTHER: Lucy Moody

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va. ?

14 Informant: Records of Balto. City Hosp.
(Address)

15 Filed 2 9 1928, 19__. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-27-29

17 I HEREBY CERTIFY, That I attended deceased from March 22, 19 29, to August 27, 19 29, that I last saw him alive on August 27, 19 29 and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute, c
Arteriosclerosis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis; Hypertension.

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Aut. PE Lab Dept Autopsy

(Signed) Warren H. McLean, M. D.

8-28, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 30 19 29
20 UNDERTAKER: Jesse St. Redden	ADDRESS 436 St. Biddle St

Spec.—1-12-23—M&T—500 Blks.

E 48853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 48853

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Carrollton Ave. WARD) 26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bennie L. Campbell

(a) RESIDENCE NO. 111 N. Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah Francis Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work minister and

(b) General nature of industry, business, or establishment in which employed (or employer) Cook 021

(c) Name of employer

9 BIRTHPLACE (city or town) Chicago
(State or country) Illinois

PARENTS

10 NAME OF FATHER Charles Campbell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not known

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known

14 Informant Sarah F. Campbell wife
(Address) 111 N. Carrollton Ave.

15 Filed Aug 29 19 29 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7" , 19 29, to Aug. 26 , 19 29.

that I last saw h alive on Aug. 26 , 19 29.

and that death occurred, on the date stated above, at 5.05 P. m.

The CAUSE OF DEATH* was as follows:

Unresolved pneumonia.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) J. A. Shelton , M. D.

, 19 (Address) 326 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 29, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 323 Schroeder

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 48854

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 630 Smyth St., 14-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hettie Johnson

(a) RESIDENCE NO. 630 Smyth ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbo. Md

PARENTS

10 NAME OF FATHER: Charles Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Elizabeth Howard

(Address) 630 Smyth St

15 Filed ....., 19.. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1927

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 19 27, to Aug 26 19 27,

that I last saw h alive on Aug 26 19 27

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F Bowers, M. D.

Aug 29 19 27 (Address) 1501 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Aug 29 19 27

20 UNDERTAKER: Samuel Wensley

ADDRESS 5 N Bridge

Spec.—1-12-23—M&T—500 Bks.

E 48855 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48855

CERTIFICATE OF DEATH. 1315

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (WARD) 175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Day

(a) RESIDENCE NO. 680 Josephine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Lottie Day

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Torchburner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash D.C.

PARENTS

10 NAME OF FATHER Edward Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27-1929

17 I HEREBY CERTIFY, That I attended deceased from 8-13-, 1929, to 8-27, 1929, that I last saw him alive on 8-27, 1929, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Peri-Nephritic Abscess
Septicaemia

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8/16/29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M.D.

8/27, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant Lottie Day

(Address) 680 Josephine St.

15 Filed AUG 29 1929 HAMPSON JONES, M. D. Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL 8/30/29

20 UNDERTAKER Mrs. Geo. E. Holland — ADDRESS 1631 Druid Hill

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48856

CERTIFICATE OF DEATH.

31 E 48856

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2009 E. Preston St. 8-17 (WARD)

2-FULL NAME James F. Quinn

(a) RESIDENCE (No.) 2009 E. Preston ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 23-1881

7 AGE: Years 47 Months 11 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Bethelam Steel Co

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Peter Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Kath Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Irland.

14 Informant: Miss May Quinn

(Address) 2009 E Preston St

15 Filed Aug 29 1929 G. HAMILTON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 28 1929.

17 I HEREBY CERTIFY, That I attended deceased from November, 1926, to August 27, 1929, that I last saw him alive on August 27, 1929, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Subacute Myocarditis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum analysis

(Signed) Francis Jay L, M. D.

Aug 29, 1929 (Address) 2006 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Aug 31 1929

20 UNDERTAKER: Geo M. Zents & Son — ADDRESS: 811 N. Eutaw

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-002

E 48857

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Dremwood

(a) RESIDENCE NO. 1113 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework ?

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER David Welch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27-29

17 I HEREBY CERTIFY, That I attended deceased from 8-21, 19 29, to 8-27, 19 29, that I last saw h.r alive on 8-27, 19 29 and that death occurred, on the date stated above, at 12 45 p. m.

The CAUSE OF DEATH* was as follows:

Unknown

(an acute polyserositis resembling rheumatic fever or Tbc)

(duration) .... yrs. .... mos. 24 ds.

CONTRIBUTORY (Secondary) Pneumococcus ?

(duration) ? yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & Bact. Autopsy

(Signed) Marvin W. H. Green, M. D.

8-27, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	Aug 29 29
20 UNDERTAKER Randall H. Hensley	ADDRESS 1718 N Bridge

Spec.—2-29-28—L. F. S.—500 Bks.

E 48858 Meyer

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48858

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 S Payson ST., 20-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Meyer

(a) RESIDENCE NO. 28 S Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2, 1863

7 AGE: Years 65 | Months 10 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Joachim Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Eichelberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Elizabeth Rechner

(Address) 156 N Chapel St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20-29

17 I HEREBY CERTIFY, That I attended deceased from 8/25, 19 29, to 8/28/29, 19 ; that I last saw him alive on 8/25/29, 19 ; and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Arteriosclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. Rosenau, M. D.

8/29, 19 (Address) 4600 Payson St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul Cemetery Violetville — DATE OF BURIAL: Aug 31 1929

20 UNDERTAKER: Charles H Rechner — ADDRESS 153 C Hollins

Important: Be sure to answer all questions. Use ditto marks (") where they apply.

OCT 9 1929 HAMILTON, MD.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48859

1—PLACE OF DEATH

REGISTERED NO. 16-76

CITY OF BALTIMORE: (No. 419 N Carey ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margie Grumbine

(a) RESIDENCE NO. 419 N Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 13, 848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Md

PARENTS

10 NAME OF FATHER Absalom Riall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminster Md

12 MAIDEN NAME OF MOTHER Elizabeth Kiefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Md

14 Informant Jola Grumbine
(Address) 419 N Carey St

15 Filed AUG 29 1929 CAMPBELL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 19 29, to Aug 26, 19 29

that I last saw h[illegible] alive on Aug 26, 19 29

and that death occurred, on the date stated above, at 3.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C N S Jones, M. D.

Sept, 19 29 (Address) 720 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md Westminster Cemetery	Aug 29 1929
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins St

IMPORTANT: DO NOT DESTROY THIS CERTIFICATE

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48860 + 194 E 48860

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1115 Gay St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Oscar A Homer

(a) RESIDENCE NO. 1017 H St. S Balto WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Bessie Abbott Homer

6 DATE OF BIRTH (month, day, and year) March 18 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Heater at OH

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel

(c) Name of employer Co Sparrows Pt Md

9 BIRTHPLACE (city or town) (State or country) Cobbs Pa

PARENTS

10 NAME OF FATHER Harry S Homer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospt Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/29

17 I HEREBY CERTIFY, That I attended deceased from 8/27/29, 19..., to 8/27/29 19..., that I last saw h.. alive on 8/27/29 19..., and that death occurred, on the date stated above, at 9 48 p.m.

The CAUSE OF DEATH* was as follows: Heat prostration

5 hrs

CONTRIBUTORY (Secondary) Contrac Poisoning (duration) yrs. 5 hrs mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sp. Pt.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo A Guy Kyle M. D.

(Address) Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Nva Ohio	Aug 29 1929

20 UNDERTAKER John P Denny ADDRESS 915 Light St

G 3 1929 HAMILTON JONES M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48861

22845 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 48861

CERTIFICATE OF DEATH

+ 21

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ozie Roten

(a) RESIDENCE NO. Lansing N C, WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER James Roten

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19 ...

C. HAMPSON JONES, M. D.

Clerk Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Aug 26, 1929, that I last saw him alive on Aug 26, 1929, and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Recurrent Empiesma

past 8 years

past attack (duration) yrs. mos. 6 0 ds.

CONTRIBUTORY (Secondary) Acute staphylococcus septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. C. Goodpasture, M. D.

Aug. 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lansing N. C.	Aug 29 1929

20 UNDERTAKER William F. Schaffer ADDRESS 16 Fremont

Spec.—2-29-28—L. F. S.—800 Blks.

Harry Wilson
3 W Biddle St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48862

CERTIFICATE OF DEATH

129

E 48862

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 411 East 31st St. 12-50 WARD)

2—FULL NAME Joseph Edward Bingley

(a) RESIDENCE NO. 1411 East 31st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Rose B. Bingley

6 DATE OF BIRTH (month, day, and year): Oct 10 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Freight Agent

(b) General nature of industry, business, or establishment in which employed (or employer): N & W R'Rd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Boone Md

PARENTS

10 NAME OF FATHER: Joseph P. Bingley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Margaret Dunnvalt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Rose B. Bingley
(Address): 411 East 31st

15 Filed ....., 19 .....

AUG 29 1929 H. HAMPTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 29

17 I HEREBY CERTIFY, That I attended deceased from September 1928, to Aug 27 1929, that I last saw h.... alive on Aug 27 1929, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Bright's Disease
(Chr. Interstitial Nephritis
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio. sclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary Exam.

(Signed) Harry E. Wilson M.D.

, 19 (Address) 3 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 30 19 29
20 UNDERTAKER: William Cook	ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Blks.

E 48863 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 48863

1—PLACE OF DEATH Baltimore City Hospitals. REGISTERED NO.

CITY OF BALTIMORE: (No. 22-30 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mattie Mattingly

(a) RESIDENCE NO. 308 S. Paca St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Thomas Mattingly

6 DATE OF BIRTH (month, day, and year) ? 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md

12 MAIDEN NAME OF MOTHER Evelyn Wooden

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md

14 Informant Records of Balto. City Hospitals
(Address)

15 Filed AUG 29 1929, 19 [illegible] Registrar

HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-28-29

17

I HEREBY CERTIFY, That I attended deceased from August 8, 19 29, to August 28, 19 29, that I last saw her alive on August 28, 19 29, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marion M. McClain, M. D.

8-28, 1929 Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL 8/31 1929

20 UNDERTAKER D. Wm. Cook — ADDRESS 1217 E. Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48864

CERTIFICATE OF DEATH

161-001

E 48864

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N Glover ST., 7-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Bednor

(a) RESIDENCE NO. 523 Glover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 2 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles W Bednor

11 BIRTHPLACE OF FATHER (city or town) Bohemia
(State or country)

12 MAIDEN NAME OF MOTHER Mary Mokal

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Charles Bednar

(Address) 523 N Glover

15 Filed AUG 29 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 29

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 29, 19..., to Aug 29 29, 19...

that I last saw h— alive on Aug 29 29, 19...

and that death occurred, on the date stated above, at 12:10 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William F Ryan M. D.

(Address) 801 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug 29 1929
20 UNDERTAKER	ADDRESS
Hunt & Son	1905 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48865

1-PLACE OF DEATH

113 E 48865

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Hopkins Hospital St., 7-10 Ward)

2-FULL NAME Dorothy Seubert

(a) RESIDENCE NO. 2313 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24/29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	XXX	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Carter Marshall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Madeline Seubert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Madeline Seubert
(Address) 2313 McElderry St

15 Filed 19 C. HAMPSON JONES, M. D., Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Intestinal Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Breen, M. D.

8/29/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemty	Aug 29, 1929
20 UNDERTAKER	ADDRESS
Wm C. Miller & Son	2554 Eft Ave

29 1929

Spec.–7-17-26—A Co.—200 Bks.

E 48866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 48866

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1227 Hollins St. 19-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Joseph Haddock

(a) RESIDENCE NO. 1533 W. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	43	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Balto & Ohio R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) Pattern Shop

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER James Haddock

11 BIRTHPLACE OF FATHER (City or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Annie Kropp

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant Mrs Annie Haddock

(Address) 1533 W. Lombard

15 Filed 2 9 1929 C. HAMPSON JONES, M. D. Registrar

By RRO

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 9, 1927, to Aug 27, 1929, that I last saw h[illegible] alive on Aug 24, 1929, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 9 mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum T.B.

(Signed) Jas L. Stooper, M. D.

Aug 28, 1929 (Address) 862 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park — Date of Burial Aug. 30 1929

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48867

CERTIFICATE OF DEATH.

E 48867

1-PLACE OF DEATH Hebrew Home for Aged & Infirm REGISTERED NO.

CITY OF BALTIMORE: (No. Lemindale & Belle ST., 17-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Rosenstein

(a) RESIDENCE NO. Hebrew Home for Aged & ~~Infirmary~~ Lemindale
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? 17 yrs. 2 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~Wife of~~ Benjamin Rosenstein

6 DATE OF BIRTH (month, day, and year) 2-5-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	86 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant L. L. Franklin R.N.
(Address) Hebrew Home for Aged & Infirm

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-29-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug-15-, 1929, to Aug-29-, 1929, that I last saw h[illegible] alive on Aug-29-, 1929 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease about one year
(duration) yrs. mos. ds.

CONTRIBUTORY none (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman Sendel, M. D.

Aug-29-1929 (Address) 2404 Entawpl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mosh Rod — DATE OF BURIAL 8/29/1929

20 UNDERTAKER Jack Levis — ADDRESS 1439 E Balto

8 29 1929

THIS is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 48868

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mollie Burroughs.

(a) RESIDENCE NO. 2054 Bank St. ST., 2 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced ~~H[illegible] of~~ (or) ~~WIFE~~ of Geo. Burroughs.

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Richard Pilkerton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Nancy Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md.

14 Informant George Burroughs. Husband

(Address) 2057 Bank St.

15 FILED AUG 29 1929, 19 C. HAMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1929, to Aug. 27, 1929.

that I last saw h e alive on Aug. 27, 1929

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm N. McFaul Jr M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Butts. Cemetery.	aug 30th 1929
20 UNDERTAKER Lilly & Zeidler Inc.	ADDRESS 403 S. Wolfe St

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48869

CERTIFICATE OF DEATH.

E 48869

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3624 Seventh St., 25-75 (WARD) 161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr. & Mrs. Theo. R. Edgar

(a) RESIDENCE NO. 3624 Seventh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1929

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Theo. R. Edgar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Ellie K. Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Theo. R. Edgar (Address) 3624 Seventh St.

15 Filed Aug 29 1929 C. HAMPSON JONES, M. D. Registrar 2861

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 29, 1929, to Aug 29, 1929, that I last saw h alive on Aug 25, 1929, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 mo.) (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 da

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell M. D.

Aug 29, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Aug 29 1929

20 UNDERTAKER

ADDRESS

Commissioner Health

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48870 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48870

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Halkis

(a) RESIDENCE NO. Reading, Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sanifer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER George Halkis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Vasiliki Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Records

(Address)

15 Filed 8-29-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29 29

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1929, to August 29, 1929, that I last saw h[illegible] alive on August 29, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Nephrolithiasis and pyonephrosis, bilateral.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of May 16, 29.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) E. A. Jones M. D.

8/29, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Redding Pa	8/29/1929
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bway

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48871

CERTIFICATE OF DEATH.

47 E 48871

1-PLACE OF DEATH

City of BALTIMORE: (No. 2915 Chelsea Terrace 15-61 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr. Julia Clara Loos

(a) RESIDENCE NO. 2915 Chelsea Terrace Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of -(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28-1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Medicine

(c) Name of employer 0

9 BIRTHPLACE (city or town) Phila.

(State or country) Pa

PARENTS

10 NAME OF FATHER Alex. Loos

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Marian Mead

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York

14 Informant Wallace Loos

(Address) 2915 Chelsea Ter.

15 Filed AUG 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

G 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Aug 29 1929 (Coroner) F. C. Leitch M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL Phila. Pa Date of Burial Aug 30 19 29

20 UNDERTAKER Wm J Tickner Sons ADDRESS N. Y & Pa.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48872

CERTIFICATE OF DEATH.

+188-203

E 48872

1-PLACE OF DEATH

City of BALTIMORE: (No.) South Baltimore General St. (Ward) 23 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and usual place of abode.)

2-FULL NAME Mary Harris

(a) RESIDENCE NO. 2603 I St. Ward Washington D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 076

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mary Windsor

(Address) 2603 I St. Wash D.C.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

2 9 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Fract Femur (Accid) St Pulm

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. ds.

(Signed) G J Fraunt M. D.

(Coroner)

8/29/1929 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Belair Rd - 23 miles from Balto.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. Date of Burial Aug 29 29

20 UNDERTAKER Samuel Beasley ADDRESS 2 Bell Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48873

CERTIFICATE OF DEATH

44 E 48873

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Stovall

(a) RESIDENCE NO. 1618 E. Madison ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record

(Address)

15 AUG 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/29

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1929, to 8/27, 1929

that I last saw h er alive on 8/27, 1929

and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma stomach

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 6/10/29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) C. H. Hampson, M. D.

8/28, 1929 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8-30th 1929
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1620 E. Mad. St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48874 — 129 — E 48874

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 2507 W. Fayette St. W-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Hoerning

(a) RESIDENCE NO. 2507 W. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Henry G. Hoerning

6 DATE OF BIRTH (month, day, and year): Aug 15th 1863

7 AGE — Years: 66 — Months: 0 — Days: 13 — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry B. Kunze

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Severin Herchenroder

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant (Address): Henry G. Hoerning 2507 W. Fayette St.

15 Filed JUN 3 1929 — C. HAMPSON JONES, M. D. Registrar — Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 28 1929

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1929 to August 28, 1929

that I last saw her alive on August 28, 1929

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Streett, M. D.

(Address) 7/29 1929 7445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. A. Cd. — Date of Burial: Aug. 30 1929

20 UNDERTAKER: Margaret G. Flynn — ADDRESS: 14 W Eight

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48875

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48875

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen. Hosp. St. 11-24 Ward)

2-FULL NAME Emma Moffett

(a) RESIDENCE NO. Owings Mills St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
White	Female	Widowed

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Jos F Moffett

6 DATE OF BIRTH (month, day, and year): Apr 7-1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	75	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Geo W Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Thos Halcock.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Calvin Richards Owings Mills Md

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Street Car.

Concussion of Brain.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 4 weeks ds.

18 Where was disease contracted? If not at place of death? Penitentiary Owings Mills

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Coroner, M. D.

(Address) Aug 27-1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Aug 30 1929
20 UNDERTAKER: Philip Herwig	ADDRESS 206 Orleans st

HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

E 48876

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland General Hospital WARD)

2—FULL NAME Mrs Emma Wheeler

(a) RESIDENCE NO. 2327 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Wheeler

6 DATE OF BIRTH (month, day, and year) January 8, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Randallstown, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Hill.

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Hospital record.
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 12th, 1929, to August 28, 1929, that I last saw her alive on August 28th, 1929 and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Indirect Inguinal Hernia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Embolism

(duration) yrs. mos. 5 mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of August 24th, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Dougherty, M. D.

(Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 31 1929
20 UNDERTAKER	ADDRESS
Henry Koch & Sons Inc	130 E Eager St

Important. See instructions on back of certificates.

G J 1929 J. HAMILTON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48877

CERTIFICATE OF DEATH

122-002

E 48877

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 Robb ST. 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James J. Burack

(a) RESIDENCE NO. 2044 Robb ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 9 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Burack

6 DATE OF BIRTH (month, day, and year) Nov. 25 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter - Self

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Burack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Catherine Burack

(Address) 2044 Robb St

15 Filed AUG 30 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1929

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Aug 29, 1929, that I last saw him alive on Aug 29, 1929, and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Mitchell, M. D.

8/30, 1929 (Address) 1779 Fulham Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 2, 1929
20 UNDERTAKER	ADDRESS
Henry Stoeck Sons, Inc.	1301 E Eager St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 48878

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp ST. 647 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Finnan

(a) RESIDENCE NO. 723 McKewin Ave E ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 8-26-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elmer Finnan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Gertrude Privette

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant Hospital Records

(Address)

15 Filed 8 30 1929 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-29

17 I HEREBY CERTIFY, That I attended deceased from 8-26-29, 19..., to 8-26-29, 19..., that I last saw h... alive on 8-26-29, 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Prematurity birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What confirmed diagnosis? Clinical

(Signed) ... M. D.

(Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hospital

DATE OF BURIAL ... 19

20 UNDERTAKER

ADDRESS

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

48879

CERTIFICATE OF DEATH

109-002 E 48879

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 805 S Glover St., 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Cierzniak jr.

(a) RESIDENCE NO. 805 S Glover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day and year): Sept. 28 - 1921.

7 AGE: Years 7 Months 11 Days IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry Cierzniak

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Frances Dembeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Henry Cierzniak (Address) 805 S. Glover St

15 Filed AUG 30 1929 C. HAMPSON JONES, M. D. Registrar

16 Per Capt.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Aug. 28 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1929, to Aug 28, 1929

that I last saw h[illegible] alive on Aug 28 (9:45 A.M.) 1929

and that death occurred, on the date stated above, at 1:20 P.m.

The CAUSE OF DEATH* was as follows: Glomerulo-nephritis.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Asthenia, Anemia, Dropsy

& Terminal Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Cardiac action.

What test confirmed diagnosis? Cessation of Respiration &

(Signed) Walter A. Anderson, M. D.

, 19 (Address) 2419 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem. Date of Burial: 8/31 1929

20 UNDERTAKER: Stephen J. Fiakowski ADDRESS: 1008 Kenwood Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 48880 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 ✓ E 48880

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp (ST., 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius Turner

(a) RESIDENCE NO. 943 Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer): infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt, Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Social Worker (Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 30 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Aug 27, 1929, that I last saw h/m alive on Aug 27, 1929, and that death occurred, on the date stated above, at 12.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

2-3 weeks

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George McDonald, M. D.

, 19 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: AUG 30 1929

20 UNDERTAKER: Commissioner Health — ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 48881

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 S. Patterson Park Ave WARD 3) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha L. Pross

(a) RESIDENCE NO. 603 S Patterson Park Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Pross

6 DATE OF BIRTH (month, day, and year) July 20, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Julius Pross

(Address) 603 S Patterson Park Ave

15 Filed ..., 19 C. H. MPSON JONES, M. D. Registrar

C 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28-1929

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to Aug 28, 1929, that I last saw h[e] alive on Aug 27, 1929 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Leukocytopenia. Tumor of Kidney

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Chas B Lemmon M. D.

Aug 29 1929 (Address) 718 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Cemetery	Aug 30 1929
20 UNDERTAKER John Tillett	ADDRESS 2008 Aliceanna

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48882

REGISTERED NO. 36 E 48882

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospital St., 5 Ward)

2-FULL NAME John Forrest

(a) RESIDENCE NO. 408 N Spring St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs

6 DATE OF BIRTH (month, day, and year): Unknown 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Common
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Virginia

PARENTS

10 NAME OF FATHER Wesley Forrest

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Va Martha Driggs
(Address) 4334 Spring

15 Filed ..... 19.. L. HAMPSON JONES, M. D. Registrar

G 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic
Arteriosclerosis (senile)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? 408 N Spring

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Benton M. D.

Aug 29. 1929 (Address) 708 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Albany cemetery	Aug 30 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1681 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48883

CERTIFICATE OF DEATH

113

REGISTERED NO. E 48883

1-PLACE OF DEATH

City of Baltimore: (No. 620 Perkins St. Aug 7-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul L. Ellis

(a) RESIDENCE NO. 620 Perkins St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day and year) Feb 23-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		6	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work No.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Paul Ellis

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Wright

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Paul Ellis
(Address) 620 Perkins

15 Filed ....., 19.... Registrar

G S 1020 C. HAMILTON JONES, M. D.
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 28 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Corner M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Aug 30 19 29

20 UNDERTAKER Samuel Wemsley ADDRESS Balto

IMPORTANT—Should be carefully answered. Every question should be answered. Unless DEATH is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 48884 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48884

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 N. Gay St. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Jones

(a) RESIDENCE 1107 Druid Hill Ave WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15, 1909.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Eugene Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mercie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mercie Jones
(Address) 1107 Druid Hill Ave

15 Filed G 30 1929 . 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 1929 to Aug 29 1929
that I last saw h alive on Aug 29 1929
and that death occurred, on the date stated above, at 12:15 P. m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No (Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Leo Price M. D.
(Address) 72 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 30 1929
20 UNDERTAKER George A Gibson	ADDRESS 1135 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48885

CERTIFICATE OF DEATH

90 ✓

E 48885

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 21-31 WARD)

2—FULL NAME Mary Louise Garrett

(a) RESIDENCE NO. 706 W. Hamburg ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
82 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER George Dearwich

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Rebecca Tenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Records of BALTIMORE CITY HOSPITALS
(Address)

15 Filed ..., 19... H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29-29

17 I HEREBY CERTIFY, That I attended deceased from 7-29, 19 29, to 8-29, 19 29,
that I last saw h[illegible] alive on 8-29, 19 29
and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Fatal

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, general ?
cerebral (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. & C. Autopsy

(Signed) Marvin M. McLean, M. D.

8-30, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wayman Good Hope Cem[illegible]

DATE OF BURIAL Sept 2 19 29

20 UNDERTAKER E H B Parker

ADDRESS 47 Washington 81

AUG 30 1929 C

Spec.—1-10-21—M&T—1500 Bks.

E 48886 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-2002 E 48886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6000 Belona ave. St. 11-24 WARD)

2-FULL NAME Isabell Dorsey.

(a) RESIDENCE NO. 1014 Cathedral ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7, 1850

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
79	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md

PARENTS

10 NAME OF FATHER Jacob T. McComas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant T. Owen Dorsey

(Address) 233 S. Rodgers Ave. Curtis Bay Md

15 Filed ... 19 ... Registrar

HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14. 1929. to Aug. 28. 1929.

that I last saw h alive on Aug. 28 1929,

and that death occurred, on the date stated above, at 12.40 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. D. Rees. M. D.

(Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Aug 30 1929

20 UNDERTAKER George J. Smith ADDRESS 1532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 30 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 48887 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48887

CERTIFICATE OF DEATH

65-081

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 14-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura R. Crum

(a) RESIDENCE NO. 229 N Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 2 ds. (Life) How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Crum

6 DATE OF BIRTH (month, day, and year) Dec. 27 1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
47	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager of Inn

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER J. S. Renner

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Maryland

12 MAIDEN NAME OF MOTHER M. V. Chilcoate

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Maryland

14 Informant Louise Crum (Daughter)

(Address) Union Memorial Hospital

15 Filed AUG 31 1929 19 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1929, to Aug. 29, 1929, that I last saw her alive on Aug 29, 1929 and that death occurred, on the date stated above, at 10:50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myeloid Leukemia

(duration) yrs. 7 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Analyses

(Signed) Jesse L. Tyler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	Sept 2 1929
UNDERTAKER George E. Smith	ADDRESS 1532 Hollins

IMPORTANT.—SEE INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48888

CERTIFICATE OF DEATH

X 118-002

E 48888

1—PLACE OF DEATH Mercy Hospital Balto Md REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Bessie Leak

(a) RESIDENCE NO. West Durham N.C. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occu[illegible] yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of widow

6 DATE OF BIRTH (month, day, and year) Jan 27 1853.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Raleigh N C

PARENTS

10 NAME OF FATHER Rev. Albert Smedes

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Y.

12 MAIDEN NAME OF MOTHER Sarah P. Lyell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Hospital Records
(Address)

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24/29

17 I HEREBY CERTIFY, That I attended deceased from 8/29/x, 19 29, to 8/29, 19 29

that I last saw h[illegible] alive on 8/29, 19 29

and that death occurred, on the date stated above, at 4 05 A m.

The CAUSE OF DEATH* was as follows:

Acute intestinal obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Surgical shock, cardiac failure (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/29/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Wm N. McFaul Jr. , M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Raleigh N. C.	Aug 31 19 29
20 UNDERTAKER	ADDRESS
John O. Mitchell Sons	Eutaw Place

important. See instructions on back of certificates.

AUG 31 1929

Spec.—2-29-2C—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48889 — CERTIFICATE OF DEATH — E 48889

1—PLACE OF DEATH — REGISTERED NO.

BALTIMORE CITY HOSPITALS 7-24

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Stevenson

(a) RESIDENCE NO. 732 George ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza

6 DATE OF BIRTH (month, day, and year): ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Va.

PARENTS

10 NAME OF FATHER: ? Stevenson

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Va.

12 MAIDEN NAME OF MOTHER: Frances ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Va.

14 Informant: Records of BALTIMORE CITY HOSPITALS
(Address)

15 Filed AUG 31 1929, 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-28-29

17 I HEREBY CERTIFY, That I attended deceased from 7-18, 1929, to 8-28, 1929, that I last saw him alive on 8-28, 1929 and that death occurred, on the date stated above, at 5 40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Interst.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Aortic insufficiency

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist: P.C.

(Signed) Warren M. McLean, M. D.

8-29, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug 31, 1929
20 UNDERTAKER: Mrs Kate R. Williams	ADDRESS 322 N Howard St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 48890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48890

Book 10-14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. WARD)

2-FULL NAME Annie Jordan

(a) RESIDENCE No. 1200 Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 15 Aug 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Micheal Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridgit Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor (Address) 1200 Valley St

15 Filed AUG 31 1929, 19.. C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929, to Aug 29, 1929, that I last saw her alive on Aug 28, 1929, and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Little Sisters Poor

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenlon, M. D.

(Address) James M. Fenlon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Joseph's - Emmitsburg Md. DATE OF BURIAL Aug 31 1929

20 UNDERTAKER Rita Windfield ADDRESS 914 Gilmor St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48891 — 29 E 48891.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

City of Baltimore: (No. 1115 Brewer St., 17-24 Ward)

2-FULL NAME James A Boyner

(a) RESIDENCE NO. 1115 Brewer St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: Years 65 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER: Edwin Boyner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant: Julia Boyner
(Address) 1115 Brewer St.

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 28th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest ..... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Edwards, M. D.

Aug 28th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem — DATE OF BURIAL 8-30 29

20 UNDERTAKER: Daniel Easton — ADDRESS 946 E Oa

IMPORTANT: Should be carefully applied. Note should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48892

CERTIFICATE OF DEATH

114 E 48892

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1420 N. Gilmor St. 15-21 Ward)

2-FULL NAME. Bernard M. Smith

(a) RESIDENCE NO. 1420 N. Gilmor St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of xx

6 DATE OF BIRTH (month, day, and year) Mar 30 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	29	4	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 610
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Daniel McNeil

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Viola Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Agnes Walker
(Address) 1420 N. Gilmor St

15 Filed AUG 30 1929, 19 — J. LANE JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Aug 29th H. Leslie Corner, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	8-30 1929
20 UNDERTAKER Daniel Easton	ADDRESS 916 Park ave

Must always be carefully supplied. ANY should be OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

✓ 48893

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48893

CERTIFICATE OF DEATH

3/ E 48898

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 935 Druid Hill Ave. ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Moore

(a) RESIDENCE NO. 935 Druid Hill ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 18. 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal Yard Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Coal do

(c) Name of employer: Enterprise Fuel

9 BIRTHPLACE (city or town) (State or country): Fitz William Co. Va

PARENTS

10 NAME OF FATHER: Andrew Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Harriet Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hattie Moore

(Address): 935 Druid Hill

15 Filed AUG 30 1929 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1929

17 I HEREBY CERTIFY That I attended deceased from Aug 1, 29, to Aug 29, 29.

that I last saw him alive on Aug 29, 29

and that death occurred, on the data stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

1½ yrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. Earl Pell, M. D.

. 19 (Address) 1131 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8-31 1929
20 UNDERTAKER	ADDRESS
Leonard Eastland	Pa ave

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48894 CERTIFICATE OF DEATH. 85 E 48894

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4002 Belview Ave ST., 15-63 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Hoyt Jones

(a) RESIDENCE No. 4002 Belview Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5- 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	81		24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired confectioner
(b) General nature of industry, business, or establishment in which employed (or employer) 819
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Girdletree Md.

PARENTS

10 NAME OF FATHER Thomas Handy Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary A. Selby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Virginia Ashburner
(Address) 4002 Belview Ave.

15 Filed ..... 19 ..... Registrar

G 8 1929 PHILIP JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-22 1929 to 8-28 1929
that I last saw him alive on 8-28 1929
and that death occurred, on the date stated above, at 1.15 9 m.
The CAUSE OF DEATH* was as follows:
Cerebral arteriosclerosis (1 day)
(duration 10-15 yrs. mos. ds.)
CONTRIBUTORY (Secondary) Fall blow on head (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis?
(Signed) Henry Mitchell M. D.
8-29 1929 (Address) 3902 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Aug 31 1929

20 UNDERTAKER Harry M. Armacost ADDRESS 42 W Ridgewood

CAUSE OF DEATH: Please write plainly with ink. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48895

CERTIFICATE OF DEATH

90

E 48895

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 N. Gilmor ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Thornton

(a) RESIDENCE NO. 926 Gilmor St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Beverly Thornton

(Address) 926 Gilmor St

15 Filed ..... 19.. JAMESON JONES, M. D. Registrar

AUG 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/29

17 I HEREBY CERTIFY, That I attended deceased from 7/15/29, to 8/28/29, that I last saw h[er] alive on 8/27/29 and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. M. Stanford Lewis, M. D.

8/29/29, 19 (Address) 912 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem.	Aug 31 1929
20 UNDERTAKER Wm. H. Grace & Son	ADDRESS 100 Mosher

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48896

CERTIFICATE OF DEATH

74-001

E 48896

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1316 N Stricker ST. 15-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Huttington

(a) RESIDENCE NO. 1316 N Stricker ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
M	C	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emeline Huttington

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 6 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Geo Huttington

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ann Harris

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Elizabeth Sawyer

(Address) 1130 N. Carey

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28, 1928

17

I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1928, to Aug. 27, 1928, that I last saw h.... alive on Aug. 27, 1928, and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cystitis (duration) about yrs. 14 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. W. Pugh M. D.

Aug. 28, 1928 (Address) 1536 N. Kenwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Aug 31 1928
20 UNDERTAKER	ADDRESS
Chas. W. Chase & Son	400 Dolphin

Important. See instructions on back of certificates.

AUG 30 1928 REGISTRAR OF VITAL STATISTICS, BALTIMORE, MD.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48897

CERTIFICATE OF DEATH

44

E 48897

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 2-5 ST. WARD)

2—FULL NAME Margaret Madeline Raum

(a) RESIDENCE NO. 3122 Guilford Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Raum

6 DATE OF BIRTH (month, day, and year) Aug 8-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mahon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Raum

(Address) 3122 Guilford Ave

15 Filed ..... 1929 C. HAMILTON JACOBS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/29

17 I HEREBY CERTIFY, That I attended deceased from 8/1x/29, 19..., to 8/28/29, 19..., that I last saw h[illegible] alive on 8/28/29, 19..., and that death occurred, on the date stated above, at 6.02 P m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Gall Bladder with Metastases to liver, etc (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/13/29

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Wm N. McFaul Jr. M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 8/31/1929

20 UNDERTAKER J. G. Moran ADDRESS Balto.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Dolan

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48898

CERTIFICATE OF DEATH

31 E 48898

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 1724 N. Wolfe St. 8-17 Ward)

2-FULL NAME Robert L. Dolan

(a) RESIDENCE NO. 1724 N. Wolfe St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19/1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51	0	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore 07
(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Frit Co
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Palto., Md.

PARENTS

10 NAME OF FATHER Patriek H. Dolan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary McDonald

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Frances Dolan
(Address) 1724 N. Wolfe St

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History By Family

(Signed) D K Brown, M. D.

8/30/29 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 8/31 1929

20 UNDERTAKER J. A. Moran

ADDRESS 300 E Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48899

CERTIFICATE OF DEATH

90 E 48899

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1422 Gough St. (Ward) 3-5

2-FULL NAME Nicholas R. Giardina

(a) RESIDENCE NO. 1422 Gough St. (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Giardina

6 DATE OF BIRTH (month, day and year) October 13 1857

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
57	8	17.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Grocery Store & Lunch Room
(b) General nature of industry, business, or establishment in which employed (or employer): Gr. self.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Giardina

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Rosia Palma

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Elizabeth Giardina
(Address) 1422 Gough St.

15 Filed ..... 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address) 1430 Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Aug 31 1929

20 UNDERTAKER Wendell J. Appel ADDRESS 308 S. Eden St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 30 1929 C. HAMPSON JONES, M.D.

Spec.—1-12-23—M&T—500 Blks.

(Schaller)

E 48900

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48900

CERTIFICATE OF DEATH

1-PLACE OF DEATH 113 s. Bouldin St., Balto, Md

CITY OF BALTIMORE: (No. 16 ST. W

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Schaller

(a) RESIDENCE NO. 113 s. Bouldin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: baby

6 DATE OF BIRTH (month, day, and year): Aug. 20, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
10 days		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): 113 s. Bouldin Balto, Md

PARENTS

10 NAME OF FATHER: Frank W. Schaller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland U.S.A.

12 MAIDEN NAME OF MOTHER: Sophia Jasik

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant: Father

(Address): 113 s Bouldin St Balto, Md

15 Filed: G 30 1929 C. HAMPSON JONES, M. D. Registrar

Fee: Paid

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/30 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/20, 1929, to 8/30, 1929, that I last saw him alive on 8/30, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): general debility (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Joseph Rosenblatt M. D.

8/30, 1929 (Address) 2018 O'Donnell, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carrollton Md. Taylorsville Cemetery	Aug 31, 1929.
20 UNDERTAKER	ADDRESS
C. M. Watts	Wingfield, Md.

CAUSE OF DEATH in plain terms. Secondary cause may be given. Indefinite terms, such as "Heart Failure," "Old Age," "Senility," "Exhaustion," "Convulsions" or "Uremia" are not sufficient. Name of disease causing death must be given. Deaths from violence must state the means and whether accidental, suicidal or homicidal. Physician is required to sign certificate and state address. Coroner is required to investigate deaths from violence and deaths occurring suddenly when deceased was not under the care of a physician. Undertaker is required to file certificate with the Registrar. Burial permit will not be issued until certificate is filed. Penalty for violation of any of the above provisions on back of certificates.

IMPORTANT See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48901

CERTIFICATE OF DEATH

161-002

E 48901

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 2-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George E. Young

(a) RESIDENCE NO. 2338 E Monument St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 24-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo E. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER E Ranch Deerfield

13 BIRTHPLACE OF MOTHER (city or town) Atlanta Ga (State or country) —

14 Informant Geo. E. Young

(Address) 2338 E Monument St

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

AUG 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 19 29 to Aug 29, 19 29

that I last saw h[illegible] alive on Aug 29, 19 29

and that death occurred, on the date stated above, at 1 30 P. M.

The CAUSE OF DEATH* was as follows:

Intra cranial Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) yrs. mos. Hours

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Spinal puncture

(Signed) [illegible], M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Lorraine — DATE OF BURIAL 8/30/1929

20 UNDERTAKER John G Cowell — ADDRESS Essex

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48902

CERTIFICATE OF DEATH

100-001

E 48902

1—PLACE OF DEATH Franklin Square Hospital

REGISTERED NO. 70-27

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H Boenzli

(a) RESIDENCE NO. German aged home Payson & Baltimore Sts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 16, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Samuel Boenzli

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Mary Eckert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Records German Aged Home

(Address) Baltimore & Payson St.

15 Filed AUG 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1929, to Aug 29, 1929, that I last saw him alive on Aug 29, 1929 and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis with uremia & Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? Yes Date of Aug 26 1929

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Dr MS Schreider M. D.

8/30, 1929 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Sept. 2 1929

20 UNDERTAKER D. Wolf B Cook

ADDRESS 1003 West Baltimore St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48903

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48903

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of Baltimore: (No. 663 W. Fayette St., 4-25 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Harrington

(a) RESIDENCE NO. 663 W. Fayette St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Harrington

6 DATE OF BIRTH (month, day, and year) Sept 27 - 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Sexton 70
(c) Name of employer .....

9 BIRTHPLACE (city or town) So. Wales
(State or country) England

PARENTS

10 NAME OF FATHER Michael Harrington

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Shea

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Michael Harrington
(Address) 3706 [redacted] York Rd

15 Filed ..... 19.....

C. HAMPSON JONES, M. D. Registrar

G 30 1929 per AKH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? .....

(Signed) Eugene Zellers M. D.

8/29. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	8/31 1929
20 UNDERTAKER Leonard J. Rucks	ADDRESS 6407 Eastern Ave

tion should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48905

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 48904

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 Gilmor ST., 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane Carter

(a) RESIDENCE NO. 747 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt	80?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hospital Records

(Address)

15 Filed 8 31 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30/29

17 I HEREBY CERTIFY, That I attended deceased from 8/27/29, 19 to 8/30/29, 19.

that I last saw h.r alive on 8/30/29, 19.

and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Ac

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma Epidermoid

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Hampson Jones M. D.

19 (Address) 1117 Gilmor St.

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	9/2 19 29
20 UNDERTAKER W. H. Cook	ADDRESS 1217 E. Fayette St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Hiss 5600 York Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48905

31 E. 48905

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Whitridge Ave ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Omar Norris

(a) RESIDENCE NO. 421 Whitridge Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arianna Norris

6 DATE OF BIRTH (month, day, and year) Feb 13, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	45	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Western Maryland

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William C Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Wiltsmm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs C Norris

(Address) 421 Whitridge Ave

15 Filed AUG 31 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Aug 29, 1929, that I last saw h— alive on Aug 29, 1929 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Hess, M. D.

Aug. 30 1929 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	8/31/1929
20 UNDERTAKER	ADDRESS
J W Cook	1317 St Paul St

important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 48906

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2830 Montebello Ave. St. 9-46 90 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Jane Pairo

(Residence in Baltimore: No. 2830 Montebello Ave., St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

6-DATE OF BIRTH, Nov. 28, 1849 (Month) (Day), 1 (Year)

7-AGE, 79 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Harford Co. Md.

PARENTS.

10-NAME OF FATHER, Walter Cunningham

11-BIRTHPLACE OF FATHER (State or Country), Harford Co. Md.

12-MAIDEN NAME OF MOTHER Maria Troutman

13-BIRTHPLACE OF MOTHER (State or Country), Harford Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin Pairo

(Address) 2830 Montebello Ave.

15- Filed AUG 31 1929, 19[illegible] C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 28, 1929 (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1929, to Aug. 28, 1929, that I saw her alive on Aug. 28, 1929, and that death occurred, on the date stated above, at 8.05P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senility (Duration) yrs. mos. ds.

(Signed) Ham. D. Gillespie M. D.

Aug. 29 1929 (Address) 415 Cedarcroft Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, 8/31, 1929

20-UNDERTAKER William Cook

ADDRESS 1217 St. Paul

William Cook

CAUSE OF DEATH must be plainly written, so that it may be properly coded. All items important. See instructions on back of certificate.

G 3 T 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 48907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 49 E 48907

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital 4-30 STREET OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Hill

(a) RESIDENCE NO. Tidewater, Va. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgia Hill

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tidewater Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant: Richard A Hill

(Address) 605 N. Gilmor St.

15 Filed 2 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1929, to Aug 28, 1929, that I last saw h live on 8-27, 1929, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) two yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory Exam.

(Signed) W. F. Draper M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sharps Neck Va.	Sept 1 1929
20 UNDERTAKER	ADDRESS
Virginia A Brooks	463 N. C[illegible]

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

2278 E 48908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

138 E 48908

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Williams

(a) RESIDENCE NO. 592 Greenmount ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40		329	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Josephine Coffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 3 1929, 19

C. HAMPSON JONES, M. D.
Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 29/29

17

I HEREBY CERTIFY, That I attended deceased from August 5, 1929, to August 29, 1929, that I last saw h[er] alive on August 29, 1929, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows: (Carbon Tetrachloride)

Generalized Peritonitis, following operation for removal of Myomatous uterus and right Tubo-ovarian abscess

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myomatous uterus - Tubo-ovarian abscess right

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of Aug 26, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. S. Everett, M. D.

8/20, 1929 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loyal Oak Park	8/29, 1929
20 UNDERTAKER	ADDRESS
Edward J. Kennedy	578 Park Ave

Cor.—10-10-29—A Co.—100 Bks.

E 48909

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48909

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of Baltimore: (No. 1375 Whatcoat St. 15-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Bond

(a) RESIDENCE No. 1375 Whatcoat St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Millie Bond.

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE: Years 58 (59) | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Helper on mov Van
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer: F A Leonard

9 BIRTHPLACE (city or town): F A Leonard
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Millie Bond
(Address): 1375 Whatcoat

15 Filed ....., 19.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 29 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Fleischmann, M. D.

Aug 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery — DATE OF BURIAL: Sept 1 1929

20 UNDERTAKER: Thomas E. Nelson — ADDRESS: 1303 Presstman St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

141

E 48910

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 1275 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irene Wittman

(a) RESIDENCE NO. 307 W Saratoga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Albert Wittman

6 DATE OF BIRTH (month, day, and year) aug 9, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~Ins~~	36	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Germany~~ Maryland
(State or country)

PARENTS

10 NAME OF FATHER Louis J Ulrich

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Braun

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Patient

(Address)

15 Filed Sep 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929, to Aug 30, 1929, that I last saw he alive on Aug 30, 1929, and that death occurred, on the date stated above, at 6:10 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation, Surgical shock

18hrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/29/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Silverburg, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	Sept 2, 1929
20 UNDERTAKER	ADDRESS
Chenowetholon	340 Chestnut Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48911

CERTIFICATE OF DEATH

177 E 48911

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2635 Barclay ST. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie A. Brooks

(a) RESIDENCE NO. 2635 Barclay ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter B. Brooks

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1888

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
41	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Monroe E. Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Lucia McCullough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. M. Chenoweth

(Address) 3615 Chestnut Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1929, to Aug. 30, 1929, that I last saw h— alive on Aug. 30, 1929 and that death occurred, on the date stated above, at 6:20 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertrophy Chronic Interstitial (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank H. Martin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Sept 2, 1929
20 UNDERTAKER Chenoweth & Son	ADDRESS 3615 Chestnut Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

4891 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48912

1—PLACE OF DEATH Union Mem. Hosp. REGISTERED NO. 12-49

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn Glassman

(a) RESIDENCE NO. Fallston, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. / How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 14, 1929

7 AGE — Years | Months: 5 | Days: 16 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vale, Md.

PARENTS

10 NAME OF FATHER: Ruben Glassman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Churchville Maryland

12 MAIDEN NAME OF MOTHER: Laura Ball

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: mother
(Address): Fallston, md.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 30, 29

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 19 29, to Aug 30, 19 29, that I last saw h2r alive on Aug 30, 19 29 and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Cerebro-Spinal fever)

(duration) ... yrs. ... mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Fallston, Md.

Did an operation precede death? No Date of

Was there an autopsy? Spinal puncture

What test confirmed diagnosis? gram neg. intracellular type

(Signed) H Hammond, M. D.

, 19 (Address) Union Mem Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, REMOVAL, CREMATION: Mt. Zion Cemetery — DATE OF BURIAL: Sept 1 19 29

20 UNDERTAKER: Hartsburgh & Goss — ADDRESS: Bel Air Md

important. See instructions on back of certificates.

G. HAMPSON JONES

SEP 1 1929

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48913 — 90 — E 48913

1-PLACE OF DEATH

City of BALTIMORE: (No. 3409 Dunraven St. 16-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wilkens

(a) RESIDENCE NO. 2822 Harlem Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Pauline A. Wilkens

6 DATE OF BIRTH (month, day, and year) July 25 1876

7 AGE Years 53 Months 7 Days 29 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Compounder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Wilkens

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Hannah Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs P. A. Wilkens (Address) 2822 Harlem Ave

15 Filed AUG 7 1929, 19 Registrar RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 19 29, to Aug 30, 19 29

that I last saw h alive on Aug 30, 19 29

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

Mitral Regurgitation

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas P Colvert M. D.

(Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Lorraine — Date of Burial 19

20 UNDERTAKER Geo W Little — ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48914

CERTIFICATE OF DEATH

89 E 48914

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N. Milton Ave. ST. 8-12 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Stengel

(a) RESIDENCE NO. 1037 N. Milton Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Stengel

6 DATE OF BIRTH (month, day, and year) July 11 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John F. Blaich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Woner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Margaret Doll

(Address) 1733 N. Milton Ave

15 Filed SEP 3 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30/29

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929 to Aug 30, 1929, that I last saw h alive on Aug. 29, 1929 and that death occurred, on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Hypertension
Months

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Herman G Yoest, M. D.

, 19 (Address) 5106 Sanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Sept 2 1929
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Eutaw St

important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48915

CERTIFICATE OF DEATH

90

E 48915

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 406 S. Pat. Pk. Ave 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julius Brown

(a) RESIDENCE NO. 406 S. Pat. Pk. Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Brown

6 DATE OF BIRTH (month, day, and year) Jan 20/1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Arthur Kraft

(Address) 406 S. Pat. Pk. Ave

15 Filed 3-1 1929, 19 ARH Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Aug 29, 1929, that I last saw h alive on 8/29 1929 and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Dis Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chas Sweet, M. D.

8/29, 19 (Address) 406 S Pat Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon P R Cem	Sept 1, 19 29
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48916

CERTIFICATE OF DEATH

90 E 48916

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1212 E. Biddle ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Rebbert

(a) RESIDENCE NO. 1212 E Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 86 yrs. — mos. — ds. How long in U. S., if foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Theodore Rebbert.

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About.	86	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Burkhardt Fahnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Gabriel Rhein

(Address) 1212 E Biddle St

15 Filed AUG 31 1929, 19 ... Registrar

Important.—See instructions on the back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30. 1929. to Date of Death 1929. that I last saw her alive on Aug. 29 1929 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows

Myocarditis - Fat. Dist. and Hypertrophy of Heart

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Aug 30/29

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam Clinical

(Signed) Edw. L. Mister M. D.

, 1929 (Address) 1224 E 33rd St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 2 1929
20 UNDERTAKER	ADDRESS
Henry Hauck Sons Inc.	1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48917

CERTIFICATE OF DEATH

46 E 48917

1—PLACE OF DEATH

REGISTERED NO. 20-71

CITY OF BALTIMORE: (No. 409 London Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. O-Brien

(a) RESIDENCE NO. 409 N London ST Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 29. 1879

7 AGE: Years 50 | Months 3 | Days X | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer): Dept Store

(c) Name of employer: O Neils

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John F O Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Grace Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Lillie O Brien

(Address): 409 N London Ave.

15 Filed: C. H. EMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 29, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929. to Aug. 29, 1929.

that I last saw her alive on Aug. 29, 1929

and that death occurred, on the date stated above, at 3.00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma, - Bladder & Vulva.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Eugene L. Pessagno, M. D.

Aug. 30 1929 (Address) 5 14 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 9-2-29

20 UNDERTAKER: Geo. A. Farley — ADDRESS: 1800 St Paul St

AUG 31 1929

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48918

CERTIFICATE OF DEATH

129 ✓ E 48918

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 329 Hale Ave ST. 20-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Schoenewolf

(a) RESIDENCE NO. 329 Hale Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (or) WIFE of: Amelia Schoenewolf

6 DATE OF BIRTH (month, day, and year): May 6, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Furniture

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Christopher Schoenewolf

11 BIRTHPLACE OF FATHER (city or town) (State or country): — Germany

12 MAIDEN NAME OF MOTHER: Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): — Germany

14 Informant: Amelia Schoenewolf

(Address): 329 Hale Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-29-29

17 I HEREBY CERTIFY, That I attended deceased from ....., 1926, to Aug 29, 1929, that I last saw him alive on Aug 29, 1929 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Sol. Wisang, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	9-2-29
20 UNDERTAKER	ADDRESS
Geo A Farley	100 N Fayette St

important. See instructions on back of certificates.

SEP 3 1929 HAMPSON JOHNS, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 48919

1—PLACE OF DEATH University Hospital

REGISTERED NO. 23-33

CITY OF BALTIMORE: (No. Saratoga ST. Queen WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Henry Reinhold

(a) RESIDENCE NO. 819 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 24 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John H. Reinhold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary E. Landon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn, Md

14 Informant Mrs John H Reinhold

(Address) 819 S Charles St

15 Filed Aug 31 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1929 to Aug 30, 1929, that I last saw him alive on Aug 30, 1929 and that death occurred, on the date stated above, at 1.0 a.m.

The CAUSE OF DEATH* was as follows:

Shock, following resection of bowel

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Intussusception

(duration) yrs. mos. 14 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 29, 1929

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. B. Johnson, M. D.

Aug. 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Aug 31 1929
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48920

CERTIFICATE OF DEATH

E 48920

1—PLACE OF DEATH

REGISTERED NO. 2423

CITY OF BALTIMORE: (No. 415 E Hamburg ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James T Bryson

(a) RESIDENCE NO. 415 E Hamburg St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Bryson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary E Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Mrs Mary E Bryson

(Address) 415 E Hamburg st

15 Filed Aug 31, 1929 C. HAMPSON JONES, M. D. Registrar

G 3 1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Aug 30, 1929, that I last saw him alive on Aug 30/29, 1929 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis & Whooping Cough

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

Aug 31, 1929 (Address) 164 W Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Sept 1 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48921

E 48921

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto Lying In (Balto Gen. Hosp.) St. 6-11 Ward)

2-FULL NAME Emil Radzie.

(a) RESIDENCE NO. 2809 Orleans St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Man	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Oct 7, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer Various Contractors

9 BIRTHPLACE (city or town) Germany

(State or country)

PARENTS

10 NAME OF FATHER William Radke

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER +

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant Emil Radke

(Address) 2809 Orleans

15 Filed _____ 19 ____ Registrar

1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Dec 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull Compound by accidentally falling from Balto G. Hosp.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Sudden

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ M. D.

(Coroner)

, 192 (Address) 1659 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds. in the General Hospital

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem Date of Burial Dec 31 1929

20 UNDERTAKER John Allcut ADDRESS 2008 Aliceanna

tion should be carefully supplied. AGE should be stated ... OF DEATH in plain terms, so that it may be properly cl... very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-002 E 48922

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella R. Mace

(a) RESIDENCE NO. 403 Bruton Place ST., Guilford WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ulysses L. Mace

6 DATE OF BIRTH (month, day, and year) Aug 24 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Sylvester Gibbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 1 1929, 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31/29

17 I HEREBY CERTIFY, That I attended deceased from August 19, 1929, to August 31, 1929, that I last saw h.er alive on August 31, 1929, and that death occurred, on the date stated above, at 11:35 A m.

The CAUSE OF DEATH* was as follows:

Recurrent Goiter

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) 0 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Aug-31/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Fred W. Sick, M. D.

8/31, 1929 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Bern, N. C.	Sept 1 1929

20 UNDERTAKER Howard & Son ADDRESS 805 N. Calvert St

IMPORTANT—Physicians are requested to fill out carefully and completely all items which are important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 48923 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48923

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4102 Maine ave St. 28-64 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Shalowitz

(a) RESIDENCE NO. 4102 Maine Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude D. Shalowitz

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balt

15 Filed SEP 1 - 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-1929

17

I HEREBY CERTIFY, That I attended deceased from Apr ..., 19 24, to Aug 30, 19 29.

that I last saw him alive on Aug 30, 19 29.

and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Ch myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Ch nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Thomashow, M. D.

8/31, 19 29 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rom

DATE OF BURIAL 9/1 19 29

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48924

CERTIFICATE OF DEATH.

1855 E 48924

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Kloher

(a) RESIDENCE NO. 309 Church Lane Pikesville St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Emma A. Kloher

6 DATE OF BIRTH (month, day, and year) Sept 6- 1867

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	61	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Co

PARENTS

10 NAME OF FATHER Adam Kloher

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Krouse

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Pa

14 Informant Mrs. John A. Kloher

(Address) 309 Church Lane Pikesville

15 Filed ..... 19 ..... H. HAMILTON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accid. Fract. Skull

Traumatic amputation right leg below knee

Prob other internal injuries

Sudden (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

Signed) H. C. Pilling, M. D.

(Coroner)

, 19 29 (Address) 1639 Bruadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs., ... mos., ... ds. State Cupid Court in the ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial Sept 2 1929

UNDERTAKER W. S. Marshall ADDRESS 3539 Old Ford

SEP 1 - 1929 C. HAMILTON JONES, M. D.

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tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48925

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 N. Calvert ST. 11-15 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles England

(a) RESIDENCE NO. 1215 N. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of ~~(or) WIFE of~~ Late Mary E. England

6 DATE OF BIRTH (month, day, and year) Oct 21st 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78 / 79		10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph England

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Middleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Joseph T. England

(Address) 215 N. Calvert St

15 Filed SEP 1 - 1929, 19 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31st 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Aug 31, 1929

that I last saw him alive on Aug 30, 1929

and that death occurred, on the date stated above, at 4.25 m.

The CAUSE OF DEATH* was as follows:

Cerebral-Spinal Arteriosclerosis.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General.

(Signed) Wm. E. Finby, M. D.

31, 1929 (Address) 4 N. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Sept 2nd 1929
20 UNDERTAKER Henry Hankins Sr. Co	ADDRESS Edmondson Ave & Gilmor St

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 48926

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-001

CERTIFICATE OF DEATH.

REGISTERED E 48926

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkin Hosp. St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Jankiewicz

(a) RESIDENCE NO. 1713 Eastern Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 27 1915

7 AGE: Years 13 Months 9 Days 2 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry Jarkiewicz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Michalina Spioch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Michalina Jarkiewicz

(Address) 1713 Easter Ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture base skull

due to auto in which he was a

rider colliding with hay car

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Traumatic Hemorrhage

(Duration) yrs. mos. ds.

(Signed) L. D. Haine M. D.

(Coroner)

8 30, 19 9 (Address) 6939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Boston & Stamford Ave

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Dept Date of Burial 2 1929

20 UNDERTAKER John M Weber ADDRESS 401 d Chester

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48927

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkin Hosp St. 24 Ward)

REGISTERED NO. 188-001 E 48927

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Jankiewicz

(a) RESIDENCE NO. 1713 Eastern Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15 1912

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Jankiewicz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Michalina Spioch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Michalina Jankiewicz

(Address) 1713 Easter Ave

15 Filed....., 19.. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

Fracture base Skull

auto in which he was riding collided with Box car -

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Traumatic Hemorrhage

(Signed) J. J. Fraile (Coroner) M. D.

Aug 30, 19 29 (Address) 2939 McElderry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Monford & Boston Sts

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Sept 2 1929

Date of Burial

20 UNDERTAKER John McUderrell ADDRESS 2 Chester

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

278618 + 90 ✓

E 48928 E 48928

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Rapfport

(a) RESIDENCE NO. Pleasantville N.J. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie

6 DATE OF BIRTH (month, day, and year) 1874 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 1 - 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to Aug 31, 1929, that I last saw him alive on Aug 31, 1929 and that death occurred, on the date stated above, at 9 15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Atlantic City N.J. DATE OF BURIAL 9/1 19 29

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 48929

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2913 Parkwood ave ST., 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah L. Krieger

(a) RESIDENCE NO. 2913 Parkwood ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? 9 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Krieger

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 72 | Months — | Days — | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ford Krieger

(Address) 2903 Parkwood ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31/29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1929, to Aug. 31, 1929

that I last saw her alive on Aug. 31, 1929

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

chronic parenchymatous nephritis

(duration) X yrs. mns. ds.

CONTRIBUTORY (Secondary): Coronary Thrombosis

(duration) yrs. mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. A. Michelson, M. D.

Sept. 1. 1929 (Address) 2230 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mutual

DATE OF BURIAL: 9/1 19 29

20 UNDERTAKER: Jack Lewis

ADDRESS 1439 E Balt St

important. See instructions on back of certificates.

E. RAMSAY JONES, M.D.

Per

Spec—12-23-21—E.B.R.S.—400 Eks.

E 48930 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5605 Greenfield Ave Ward) 24-43

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George P. Keener

(a) Residence No. 5665 Greenfield ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Smythe Keener

6-DATE OF BIRTH (month, day and year) Nov 8, 1849

7-AGE. ~~8~~ 79 yrs. 9 mos. 22 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steamfitter

(b) General nature of industry, business, or establishment in which employed (or employer) 60

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John F. Keener

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Annie Virginia Smythe

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Baltimore

14- (Informant) Nina Margaret Keener

(Address) 5605 Greenfield Ave

15- Filed SEP 1 - 1929 THOMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 31, 1929

17- I HEREBY CERTIFY, That I attended deceased from August 29 1929 to August 31 1929 that I last saw him alive on August 30 1929 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

apoplexy.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) anaemic

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at his residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Geo. C. E. Tyler M. D.

, 19 (Address) Hamilton Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space None.

19-PLACE OF BURIAL, CREMATION OR REMOVAL?	DATE OF BURIAL.
Baltimore Cemetery	Sept 2, 1929
20-UNDERTAKER. Robt F. Turner & Son	ADDRESS 1442 N Broadway

Should be carefully considered and answered in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

E 48931

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48931

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland St., T-13 WARD)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Manaback

(a) RESIDENCE NO. Sinai Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Manaback

6 DATE OF BIRTH (month, day, and year) Sept 4 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	85	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hirben. (State or country) Bavaria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Flora —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Hosp. Records (Address)

15 Filed SEP 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Sept 1, 1929, that I last saw her alive on Sept. 1, 1929, and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Generalized arteriosclerosis unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clin-history & phys. findings

(Signed) Jac of St. Conn, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Shalom Cem

DATE OF BURIAL 9/2 1929

20 UNDERTAKER Harris Sanderson

ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E48932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 48932
E 48932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 6-10 Ward)

2-FULL NAME John Henry Einhaus

(a) RESIDENCE NO. 115 N. Belnord Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Eva Einhaus

6 DATE OF BIRTH (month, day, and year) May 14/1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	72	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) (Retired)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Eva Einhaus
(Address) 115 N. Belnord Ave

15 Filed SEP 1 1929 C. HAMPSON JOHNS, M. D. Registrar.

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - Shot himself with revovver behind rt. ear. (Suicide)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/31/29 19 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Otsmo Cemetery Co.	Sept 2 1929
20 UNDERTAKER	ADDRESS
Hughes & Jones Inc	424 N. Broadway

N. B.—WRITE PLAINLY, with ink. Every question should be carefully answered. If unknown, so state. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Blks.

E 48933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 VE 48933

E 48933,

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 405 N Carey St. (STREET OR AVENUE) (WARD)

2-FULL NAME Mr Edward Duckhardt

(a) RESIDENCE. No. 405 N. Carey St. ST., WARD. H. & W. 9/4/19.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Duckhardt.

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Graham Duckhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Priscilla Harmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Duckhart (Address) 405 N Carey St

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1929

17

I HEREBY CERTIFY, That I attended deceased from August 10, 1929, to Aug 30, 1929,

that I last saw h[illegible] alive on Aug. 30, 1929,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 10 yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry E. Wilson M. D.

, 19 (Address) 13 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 9/2 29

20 UNDERTAKER W. H. Storck ADDRESS 409 Valentine Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 1 - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48934

CERTIFICATE OF DEATH

E 48934

1—PLACE OF DEATH

REGISTERED NO. 91-002 48934.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5824 York Road ST. 27-48 WARD)

2—FULL NAME Rev. George Scholl D.D.

(a) RESIDENCE NO. 5824 York Road ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Emma Barr (Scholl)

6 DATE OF BIRTH (month, day, and year) April 22nd 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	4	8	

8 OCCUPATION OF DECEASED

(a) ~~Trade~~, profession ~~or~~ particular kind of work Clergyman

(b) ~~General~~ nature of industry, business, ~~or establishment~~ in which employed ~~(or employer)~~ 018

(c) Name of employer

9 BIRTHPLACE (city or town) Near Connersville
(State or country) Indiana

PARENTS

10 NAME OF FATHER John F. Scholl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Elizabeth Reed

13 BIRTHPLACE OF MOTHER (city or town) Schuylkill Co,
(State or country) Penna.

14 Informant Maud S. Scholl Cattanach
(Address) 5824 York Road

15 Filed SEP 1 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1929, to Aug 29, 1929, that I last saw h. im alive on Aug 29, 1929 and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis, Senility,
Failing heart, 2 years
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. O'Connor, M. D.

19 (Address) 5836 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept 2 1929

UNDERTAKER: Chas. H. Black Sons — ADDRESS: Baltimore

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48935

E 48935

CERTIFICATE OF DEATH

REGISTERED NO. E 48935

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene Hafley

(a) RESIDENCE NO. Westminster, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Inf

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/29/27

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Raymond Hafley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Virgie Myerly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed SEP 1 1929, 19 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1929, to Sept 1, 1929, that I last saw h.. alive on Sept 1, 1929 and that death occurred, on the date stated above, at 11 55a m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentary

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Westminster, Md

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological culture

(Signed) V. C. Godwin, M. D.

9/1, 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Bur. Co

DATE OF BURIAL 9/4 1929

20 UNDERTAKER H. Bankard & Son

ADDRESS Westminster

OF DEATH in plain terms, so that it may be properly classified. Every certificate should be filled out in every particular, as all the items are important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

~~E 4560~~ E 48936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 84 E 48936

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ora Arbogast

(a) RESIDENCE NO. Parsons W. Va ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 2-14-70

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
59	6	18 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Henry Arbogast

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Judy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 1 1929 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1929

17 I HEREBY CERTIFY, That I attended deceased from August 27, 1929, to Sept 1, 1929, that I last saw him alive on Sept 1, 1929 and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor Surg.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 27 Aug 29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) E H Campbell M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parson W Va — DATE OF BURIAL 9/2/29

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

148

E 48937.

1—PLACE OF DEATH Franklin Sq. Hosp REGISTERED NO.

CITY OF BALTIMORE: (No. 23-37 ST WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. annie Marshal

(a) RESIDENCE NO. 1626 Light ST ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Marshall

6 DATE OF BIRTH (month, day, and year) Sept 27 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Marshall

(Address) 3402 Belvedere Ave

15 Filed ....., 19.... ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1. 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Sept 1, 1929, that I last saw h alive on 9-1, 1929 and that death occurred, on the date stated above, at 3:50 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Mos 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy & eclampsia (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory & clinical findings

(Signed) Dr. Nb Schreibes, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	9/3 1929
20 UNDERTAKER	ADDRESS
W. Cook	1217 E Lord St

OF DEATH in plain terms, so that it may be properly classified. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 are important. See instructions on back of certificates.

SEP 2 - 1929 THOMPSON JONES M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

Hengelmann

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48938

CERTIFICATE OF DEATH

46 ✓ E 48938

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balt City Hosp ST. 19-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Hengelman

(a) RESIDENCE NO. 1330 Hollins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Hengelman

6 DATE OF BIRTH (month, day, and year) March 28. 1898 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Joseph Sawlaski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record (Address)

15 Filed SEP 2 - 1929 by HAMPSON JONES M D Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31/29

17 I HEREBY CERTIFY, That I attended deceased from 8/26, 1929, to 8/31, 1929

that I last saw her alive on 8/30, 1929

and that death occurred, on the date stated above, at 4:40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma cervix

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to lungs

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. H. Thompson M. D.

8/31, 1929 (Address) Balt City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	9/3 1929
20 UNDERTAKER J. W. Cook	ADDRESS 1217 St Paul

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Stowell 715 Frederick Rd

E 48939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-007 ✓ E 48939

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N High ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabelle Doyle

(a) RESIDENCE NO. 223 N High ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Doyle

6 DATE OF BIRTH (month, day, and year) Oct. 4 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer At Home

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Angelo Grossi

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Teresa Malnetti

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) France

14 Informant Gabrielle Leslie

(Address) 223 N High St

15 Filed SEP 2 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Aug 30, 1929, that I last saw her alive on Aug 28, 1929, and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

I Stomach Arthritis
Chr Bronchitis

(duration) 24 yrs mos ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs mos. 8 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) James Stowell, M. D.

19 (Address) 715 Frederick Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	9/2 1929
20 UNDERTAKER J. M. Cook	ADDRESS 1217 St Paul St

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly

Spec.—8-24-14—M. & T.—2000

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48940

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

13-52 90

E 48940

REGISTERED No. C

CITY OF BALTIMORE: (No. 4129 Roland Av ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Margaret A. Childs.

(Residence in Baltimore: No. 4129 Roland Ave. 50 yr.

St.; 67 yrs. 8 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White.	Widow

6-DATE OF BIRTH. March (Month) 2 (Day), 1862 (Year)

7-AGE.	If LESS than 1 day,
67 yrs. 8 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Laurel Md.

PARENTS.

10-NAME OF FATHER, Wm. Andrews.

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Dibley

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Lorenz J. Childs.

(Address) 4129 Roland Ave.

15-

Filed SEP 2 1929, 19..

THOMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. August (Month) 31 (Day), 1929. (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to Aug. 30, 1929, that I saw her alive on Aug. 30, 1929, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hugh Forsythe M. D.

8/31, 1929. (Address) 424 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, 9/2, 1929

20-UNDERTAKER Wm. Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

222094 **E 48941**

CERTIFICATE OF DEATH

65-00

E 48941

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Westaway

(a) RESIDENCE NO. 2740 Wilkins Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 4 mos. 14 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian

6 DATE OF BIRTH (month, day, and year) April 16, 1894 unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Westaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mollie Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 2 - 1929 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30-1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929, to Aug 30, 1929

that I last saw h.. alive on Aug 30, 1929

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) George Packa Berry, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Sept. 2, 1929

20 UNDERTAKER Harry A. Wittle, 1533 W. Fayette

ADDRESS Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Edward Weidner

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 48942

1—PLACE OF DEATH

REGISTERED NO. E 48942

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. City Hospital ST. No 3 (WARD).

2—FULL NAME Edward L. Weidner (Weidner)

(a) RESIDENCE NO. 3313 Eastern Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Lee Weidner

6 DATE OF BIRTH (month, day, and year) 1873 Aug 9

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	56	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lee Weidner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records.
(Address)

15 Filed SEP 2 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1929, to Aug 31, 1929, that I last saw him alive on Aug 31, 1929, and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) T.B Exudative & Laryngitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Jas Grinnell M. D.

19 (Address) City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	19 SEP 3 1929
20 UNDERTAKER Geo W Little	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Enter statement of OCCUPATIONS as carefully and as full as important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48943
1—PLACE OF DEATH

REGISTERED NO. **E 48943**
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3315 Dupont Ave. ST. 27-56 WARD) 31

2—FULL NAME Winifred Marie Pullman,

(a) RESIDENCE NO. 3315 Dupont Ave. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) March 3.1907

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ------

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. F. Pullman,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Carolym M Hulsebus,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Carolym M. Pullman,
(Address) 3315 Dupont Ave

15 Filed SEP 2 1929, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31/29.

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 19 29, to August 31, 19 29
that I last saw h[illegible] alive on August 31, 19 29
and that death occurred, on the date stated above, at 3.45 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm D. Bubert, M. D.
19 (Address) 4754 Park Heights Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 19

20 UNDERTAKER Geo W Little — ADDRESS

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48944
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 E 48944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. Mt St Joseph College ST. WARD)

2-FULL NAME Brother Mark Kinsella

(a) RESIDENCE NO. Mt St Jos. College ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25/1851

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Newfoundland
(State or country)

PARENTS

10 NAME OF FATHER —Dk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dk

12 MAIDEN NAME OF MOTHER Dk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dk

14 Informant Bro Thurston
(Address) Mt St J. College

15 Filed SEP 2 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Sept 1, 1929, that I last saw h[e] alive on Sept 1, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Ptc Sept. Nephritis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) 20 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. J. Lucid, M. D.

9/ , 19 9 (Address) Kingston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Sept 2 1929

20 UNDERTAKER Fred a Kiausekar — ADDRESS 703 Hamilton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48945

CERTIFICATE OF DEATH.

90 E 48945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 3316 Sinto St

CITY OF BALTIMORE: (No. Fairfield ST. 25-26 WARD)

2-FULL NAME Jennie Campher

(a) RESIDENCE NO. Fairfield ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dick Campher

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hse

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emelia Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Dick Campher

(Address)

Filed SEP 2 1929 W. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929, to Aug 30, 1929, that I last saw her alive on Aug 30, 1929 and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Bruck M. D.

1929 (Address) Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See teverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL 9-2 1929

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill

Ont

Spec.—1-10-21—M&T—1500 Bks. should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48946

CERTIFICATE OF DEATH

188-103

E 48946

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp- St. 18-76 Ward)

2-FULL NAME William Edwards

(a) RESIDENCE NO. 897 W Fairmount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	M. Dowd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wd Dowd

6 DATE OF BIRTH (month, day, and year) Dont know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63	(Estimated)		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal & Wood Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) —self—
(c) Name of employer —self—

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know

14 Informant Isaac Edwards
(Address) 215 N. Schroeder

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29 192 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Fibers
auto struck cash cart door it out door plinky man sitting inside

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupt Urethra

Edema Lungs (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? in front of 897 Fairmount

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L. J. Frame, M. D.

31 . 1929 (Address) 2929 W Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	9-3 1929
20 UNDERTAKER	ADDRESS 1037 Hund Hill
John H. Toadvine	

SEP 2 - 1929 HARRISON BOOKS, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 48947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 48947

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3503 Cedardale Rd (St.) 15-62 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frazier

(a) RESIDENCE No. 3503 Cedardale Rd St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Frazier

6 DATE OF BIRTH (month, day, and year): Nov. 26 1840

7 AGE — Years: 88 — Months: 9 — Days: 5 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Charles Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Eliza ?.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: C. C. Frazier

(Address): 3503 Cedardale Rd

15 Filed SEP 2 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1 1929

17

I HEREBY CERTIFY, That I attended deceased from June 28th, 1929, to September 1st, 1929, that I last saw her alive on Sept. 1st, 1929, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Cardio - Vascular Renal Senility -

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. P. Syerly M. D.

9/1, 1929 (Address) 604 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newburg Md

DATE OF BURIAL: Sept 2 1929

20 UNDERTAKER: Wm J Tickler Sons

ADDRESS: Newburg Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48948

CERTIFICATE OF DEATH.

91-00 E 48948

E 48948
1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1525 N. Eden St. St. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora Steinmeier

(a) RESIDENCE NO. 1525 N. Eden ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Jas. Gravenstein

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emily Wright.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant L. M. Simpson
(Address) 1525 N. Eden St.

15 Filed SEP 2 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1929, to Aug. 31, 1929.

that I last saw her alive on Aug. 31, 1929.

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(duration) 15 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) Philip B. Fowler, M. D.

(Address) 1432 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Sept 3 1929

20 UNDERTAKER Henry Lutz ADDRESS 1203 N. Broadway

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 48949

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thelma Marie Davis

(a) RESIDENCE NO. Eastern Ave and Lakeside ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) child

If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Aug 26, 1929

7 AGE Years Months Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Fred Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Thelma Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Hospital Record

(Address)

15 Filed SEP 2 1929, 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1929, to Sept. 1, 1929.

that I last saw her dead alive on Sept 1, 1929

and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of August 27, 1929

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Samuel J. Nelson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Aug 4 1929

20 UNDERTAKER George W Zitkus — ADDRESS 1737 Eager St

IMPORTANT—Cause of death must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Shoon

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 48950

CERTIFICATE OF DEATH

E 48950

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hospital ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Shoon

(a) RESIDENCE NO. 230 W. Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Chinese	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0 #1

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Hospital Record
(Address)

15 Filed Sept 2 1929 C. HAMILTON JONES, M. D. Registrar

P 2 - 1929 AT

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30/29

17

I HEREBY CERTIFY, That I attended deceased from 8/26, 1929, to 8/30, 1929

that I last saw him alive on 8/30, 1929

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Cellulitis left side of face

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 8/27/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. A. Crompton, M. D.

8/30, 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 2 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Ruzicka 161 - 08 00 1 Dar Ok Gen

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48951

CERTIFICATE OF DEATH

E 48951

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2321 Ashland Ave ST., 12 WARD)

2—FULL NAME Lon Ewell

(a) RESIDENCE NO. 2321 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29. 1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Oscar B Ewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Pearl Schulz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Oscar B Ewell

(Address) 2321 Ashland Ave

15 Filed SEP 2 - 1929, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 19 29 to Aug 31, 19 29

that I last saw h alive on Aug 31, 19 29

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows: Premature Birth

1/2 two Fetus

CONTRIBUTORY (Secondary) Accident Suffocation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred Lurz M. D.

19 29 (Address) 600 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	9/2 19 29
20 UNDERTAKER Wm Cook	ADDRESS 1214 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Montgatroyd 31 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48952

CERTIFICATE OF DEATH

E 48952

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3021 E Monument ST., 7-11 WARD)

2—FULL NAME Louis Schlickenmaier

(a) RESIDENCE NO. 3021 E Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lora Schlickenmaier

6 DATE OF BIRTH (month, day, and year) June 10 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Clement & Ball

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Schlickenmaier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Timothy Schlickenmaier

(Address) 3021 E Monument St

15 Filed SEP 2 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17R, 19 29, to Aug 31st, 19 29, that I last saw h~ alive on Aug 30R, 19 29 and that death occurred, on the date stated above, at 10.30P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X Ray

(Signed) Geo. W Montgomery M.D.

9/4, 19 29 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL 9/3 1929

20 UNDERTAKER W. M. Cook — ADDRESS 1211 E Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48953

CERTIFICATE OF DEATH

44. E 48953

1—PLACE OF DEATH Balto City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 2-4 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanley Bruzinski

(a) RESIDENCE NO. 412 S Chester ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city [illegible] mon. ds., How long in U. S., if [illegible]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	7	Unknown	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown
(State or country) Poland

PARENTS

10 NAME OF FATHER Stanley Bruzynski

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown

14 Informant Balto City Hosp Records
(Address)

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-29

17 I HEREBY CERTIFY, That I attended deceased from 8-10—, 1929 to 9-1—, 1929

that I last saw him alive on 9-1—, 1929

and that death occurred, on the date stated above, at 8 15 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY 1. Cancerous ulcer stomach
(Secondary)
2. Senility (duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray, G.I. series

(Signed) Fred M. Shinkman, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary C	Sept 3 1929

20 UNDERTAKER F W Ozarowski ADDRESS 1730 Eastern Ave

FEB 2 - 1929 Harrison Jones M.D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 48954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48954

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 5-8 ST., WARD)

2-FULL NAME Mrs. Rachel Rubin

(a) RESIDENCE NO. 504 Saquith ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Jacob Rubin

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Dunnerstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dunnerstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Record

(Address)

15 Filed SEP 2 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-12, 1929, to 9-1, 1929, that I last saw h alive on 9-1, 1929, and that death occurred, on the date stated above, at 8 PM m.

The CAUSE OF DEATH* was as follows: Chalecystitis Cholelithiasis auricular fibrillation

(duration) 8 wks mos. ds.

CONTRIBUTORY (Secondary) auricular fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/19/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Sidney L Bauer M. D.

1. 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Road | DATE OF BURIAL 9/2 1929

20 UNDERTAKER Sol Levinson & Bro | ADDRESS 1127 E Balto st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 48955 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 48955

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 N Carey ST. 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carey Gambrill

(a) RESIDENCE NO. 1033 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 3, 1912

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
17	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm H Gambrill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Estella Toney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Estella Gambrill (Address) 1033 N Carey

15 Filed SEP 2 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1929, to Aug 31, 1929, that I last saw him alive on Aug 31, 1929, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) W H Gambrill, M. D.

(Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9-3 1929

20 UNDERTAKER: Geo T A Gibson & Sons

ADDRESS 1738 W. Fayette

CAUSE OF DEATH in plain terms. so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

NATION Should Be Carefully Supplied. AGE Should

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48956 188-1923 E 48956

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1005 Parkesley St. 20-70 Ward)

2-FULL NAME J Leo Hamilton

(a) RESIDENCE NO. 1005 Parkesley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of Alice Van Vorst

6 DATE OF BIRTH (month, day, and year) Mar 10 - 1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	72	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jno G. Hamilton

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Austin

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant John H. Hamilton
(Address) 1005 Parkesley Ave.

15 Filed 19 C. HARRISON JONES, M. D. Registrar

SEP 2 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptr Liver
Struck by auto at intersection
knocked down - proceeded to
home after Hospitalization (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Fremont & Fayette

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Franz M. D.

(Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 3 1929

20 UNDERTAKER Harry H. Wirtzbach & Bro. ADDRESS Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 48957

REGISTERED NO.

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 1250 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Wright

(a) RESIDENCE NO. 2330 ? Edmondson Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Va.

PARENTS

10 NAME OF FATHER Thomas Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Va.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? ?

14 Informant: Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed SEP 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-29

17 I HEREBY CERTIFY, That I attended deceased from 8-27, 1929, to 8-31, 1929.

that I last saw him alive on 8-31, 1929

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic

(duration) over 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Wass. & Lab.

(Signed) Marvin M. McLean, M. D.

9-1, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 9/2 1929

20 UNDERTAKER: Samuel T. Hemsley — ADDRESS 578 N. Bond

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48958

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 48958

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 421 N. Pearl St., 17-25 Ward)

2-FULL NAME Mary Brooks Roane

(a) RESIDENCE NO. 429 N. Pearl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Nicholas Roane

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant James Reed
(Address) 421 N. Pearl St

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

SEP. 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.

9/2, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	9/2 1929
20 UNDERTAKER	ADDRESS
Frank T. Llewellyn	578 N. Bridle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48959 — 90 — E 48959

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 312 S. Caroline St. 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morris Abrams

(a) RESIDENCE NO. 312 S. Caroline ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE Rhind Abrams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Cohen

(Address) Wash. D. C.

15 Filed SEP 2 - 1929 H. BRYSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1929

17 I HEREBY CERTIFY, That I attended deceased (from Aug 16 1929 to Aug 31 1929

that I last saw him alive on Aug. 31 1929

and that death occurred, on the date stated above, at 5.05 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Renal asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hrs Hellerman M. D.

9/1 1929 (Address) 515 N Bentalou st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northwood Va — DATE OF BURIAL 9/2 1929

20 UNDERTAKER Jack Lewis — ADDRESS 1489 E Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48960

74-001

E 48960
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 5820 York Rd St. 27-28 Ward

2-FULL NAME John H. Boommelsick

(a) RESIDENCE NO. 5820 York Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) July 15 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	75	0	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Peter H. Broomelsick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Fricke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna Broomelsick
(Address) 5820 York Road

15 Filed ..... 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What were confirmed diagnosis?

(Signed) G. C. Gladden, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	9/2 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 Park Ave

SEP 1 1929 THOMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48961

CERTIFICATE OF DEATH

9

1—PLACE OF DEATH

REGISTERED No. E 48961

CITY OF BALTIMORE: (No. Sydenham Hospital 2131 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME DEWEY SANDS

(a) RESIDENCE NO. 421 E. Hamberg ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Sands

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md —

12 MAIDEN NAME OF MOTHER Clive Thompkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Queen Annes Co Md

14 Informant James Sands
(Address) 421 E. Hamberg St.

15 Filed SEP 2 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 1, 1929, that I last saw him alive on Sept 1, 1929, and that death occurred, on the date stated above, at 4 20 p.m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) Malnutrition (improper feeding) (duration) 0 yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? 421 E. Hamberg St.

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical findings

(Signed) Addison Croft Phys. M. D.

9-1, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A. A. Co	Sept 1 1929
20 UNDERTAKER Margaret E. Flynn	ADDRESS 422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48962

CERTIFICATE OF DEATH

E 48962
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5706 Oakshire Road ST. Mt Wash 27-54 WARD)

2—FULL NAME Charles James Benson

(a) RESIDENCE NO. 108 Woodlawn Road ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 59 yrs. 2 mos. 30 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Maud E. Benson

6 DATE OF BIRTH (month, day, and year) May-31-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President of the

(b) General nature of industry, business, or establishment in which employed (or employer) C. J. Benson Co.

(c) Name of employer Self

9 BIRTHPLACE (city or town) New York City
(State or country) New York

PARENTS

10 NAME OF FATHER Rodney Benson

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Catharine VanBergen

13 BIRTHPLACE OF MOTHER (city or town) Catskill
(State or country) New York

14 Informant Mr. Louis L. Schwartz (Friend)
(Address) 501-N-Charles Street

15 Filed ....., 19 .....
Per ..... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30/29

17 I HEREBY CERTIFY, That I attended deceased from Sept., 1926, to May 4th, 1929, that I last saw h[illegible] alive on May 4, 1929 and that death occurred, on the date stated above, at about 7A m.

The CAUSE OF DEATH* was as follows:

Myocardial weakness

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

9/1, 1929 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Sept-4-1929.
20 UNDERTAKER	ADDRESS
Stewart & Mowen Company	128-W-North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48963

CERTIFICATE OF DEATH

E 48963

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 70

CITY OF BALTIMORE: (No. ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Grabowski

(a) RESIDENCE NO. 1222 S. Ellwood ~~ST.~~ Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Grabowski

6 DATE OF BIRTH (month, day, and year) Nov. 22 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER William Grabowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Poland

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Poland

14 Informant Records

(Address)

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-29

17 I HEREBY CERTIFY, That I attended deceased from 8-23, 1929, to 8-31, 1929, that I last saw him alive on 8-31, 1929 and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure (undetermined origin)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Post Mortem Law Autopsy

(Signed) Marvin M. McLean, M. D.

9-1, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus DATE OF BURIAL Sept. 4 1929

20 UNDERTAKER Stephen J. Fishowitch ADDRESS 1048 Kenwood Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Blks.

E 48964 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 48964
Registered No.

1-PLACE OF DEATH
City of BALTIMORE: (No. 2715 Hait Ave St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Sophia) Struzala

(a) Residence No. 2715 Hait Ave St., Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 35 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-Single, Married, Widowed, or Divorced: Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Struzala

6-DATE OF BIRTH (month, day and year): 1874.

7-AGE: 58 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House
(b) General nature of industry, business, or establishment in which employed (or employer): Wife
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.
10-NAME OF FATHER: John Kubowski
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14-
(Informant): Albert Struzala
(Address): 2715 Hait Ave

15-
Filed SEP 2 - 1929 192
C. HAMPSON JONES, M. D.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 31/29.

17- I HEREBY CERTIFY, That I attended deceased from August 24 1929 to August 31 1929
that I last saw h.er alive on August 30 1929
and that death occurred, on the date stated above, at 12 20 m.
The CAUSE OF DEATH* was as follows:

Myocardiac Insufficiency

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Secondary Anemia
(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Joseph Rosenblatt M.D. M. D.
8/31 1929 (Address) 3018 O'Donnell St Balto md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus
DATE OF BURIAL: Sept 3 1929

20-UNDERTAKER: Stephen Faulkowski
ADDRESS: 1000 S Kenwood Ave

Inc

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48965

CERTIFICATE OF DEATH

89

E 48965
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. 2 N Potomac St., 6-11 Ward)

2-FULL NAME Andrew J Jennings

(a) RESIDENCE NO. 2 N Potomac St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Jennings

6 DATE OF BIRTH (month, day, and year) Jan 21, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51	7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Jennings

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Julia Cahill

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Mary Jennings
(Address) 2 N. Potomac St

15 Filed SEP 3 - 1929 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pect
Exhaustion
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G Grant Hyland M. D.
19 (Address) 1438 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Harford Rd	Sept 3 1929
20 UNDERTAKER Margaret D. Flynn	ADDRESS 417 Light St.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 48966

CERTIFICATE OF DEATH.

E 48966

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry E Reynolds Jr

(a) RESIDENCE No. 1316 N. Lexington St. (ST.) ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 25th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
4 moo	0	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Harry Reynolds

11 BIRTHPLACE OF FATHER (city or town) Penna
(State or country)

12 MAIDEN NAME OF MOTHER Augustine Meeks

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Harry Reynolds
(Address) 1316 N. Lexington St

15 Filed SEP 3 1929, 19.. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-31, 1929, to 9/2, 1929.

that I last saw him alive on 9/2 1929

and that death occurred, on the date stated above, at 1 30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumania
Meningitis (?)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. — DATE OF BURIAL Sept 3 1929

20 UNDERTAKER John J Bowers Son — ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48967

CERTIFICATE OF DEATH

'31 16-002

E 48967

1—PLACE OF DEATH
CITY OF BALTIMORE. (No.) South Baltimore General ST., Hospital WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Donald Snell

(a) RESIDENCE NO. 601 W. West ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Son

6 DATE OF BIRTH (month, day, and year) Oct 22 1922

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
6	10	12 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Roy Snell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Mary Snell

(Address) 601 W West St

Filed 1929, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-29

17 I HEREBY CERTIFY, That I attended deceased from 9-1, 19 29, to 9-1, 19 29

that I last saw him alive on 9-1, 19 29

and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Dysentery

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) Joseph Louraitis, M. D.

19 (Address) South Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 4, 1929
20 UNDERTAKER Chas. R. Stevens	ADDRESS 2 Fort Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Robert Baker

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48968

E 48968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hospital St., 7-13 Ward)

2-FULL NAME Robert Baker

(a) RESIDENCE NO. 834 N. Bond St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mattie Baker

6 DATE OF BIRTH (month, day, and year) July 1/1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33	1 1	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N.C.

PARENTS

10 NAME OF FATHER Wm. Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14 Informant Mattie Baker
(Address) 834 N. Bond St

15 Filed SEP 3 1929, 19 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Abcess-Infection of Mastoid, middle & internal ear. Rt. side.
Endocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) L. P. Yoe M. D.

9-3-29 19 (Address) 508 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashburn Cemetery DATE OF BURIAL: Sept 3 29

20 UNDERTAKER: Chas. H. Johnson ADDRESS: 1446 N. Caroline St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓

E 48969 REGISTERED NO. E 48969

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2441 E. Biddle ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophia Steiger

(a) RESIDENCE NO. 2441 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Steiger

6 DATE OF BIRTH (month, day, and year) Feb'ry 3, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	48	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 077

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Soffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm. Steiger

(Address) 2441 E. Biddle St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to August 31, 1929 that I last saw h.. alive on August 31, 1929 and that death occurred, on the date stated above, at 2045 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray + Sanitarium

(Signed) Thos. A. Stevens, M. D.

9/1, 1929 (Address) 2878 Hurford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	9/3 1929
20 UNDERTAKER	ADDRESS
W. H. Cook	2150 Pond St

mation should be carefully supplied. Also should OF DEATH in plain terms, so that it may be pro important. See instructions on back of certificate

SEP 3 1929 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Grant 3217 Westwood Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48970

E 48970

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Orem Ave ST. 43-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Staines

(a) RESIDENCE NO. 2211 Orem Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mollie Staines

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE — Years: 68 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: City of Baltimore

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Albert Staines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rachel E Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Sophia Eckert

(Address): 2211 Orem Ave

15 Filed ....., 19.. E. HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/1 10 a.m. 1929, to 9/1 1929, that I last saw h[illegible] alive on 9/1 1929, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? No —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Usual examinations

(Signed) Hom. Grant, M. D.

, 19 (Address) 3217 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 9/4 1929

20 UNDERTAKER: Wm. Cook

ADDRESS: 127 St Paul St

...mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48971 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 48971

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 E Fruston ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis M Sprague

(a) RESIDENCE NO. 918 E Fruston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud M Sprague

6 DATE OF BIRTH (month, day, and year) March 24 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot do

(b) General nature of industry, business, or establishment in which employed (or employer) Steamboat

(c) Name of employer Md. Pilot Assn

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs Maud M Sprague

(Address) 918 E Fruston St

15 Filed SEP 3 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1929, to Aug 31, 1929, that I last saw h.. alive on Aug 21, 1929 and that death occurred, on the date stated above, at 12:10 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hiram Fried, M. D.

, 19 (Address) #316 Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 9/4 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

mation should be carefully supplied. All statements must be proper OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 48972

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Cole

(a) RESIDENCE NO. 1200 Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown Cole

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Little Sisters of the Poor

(Address) 1200 Valley St.

15 Filed ....., 19.... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929, to Aug 31, 1929, that I last saw h.. alive on Aug 31, 1929 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1200 Valley

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H Fenton, M. D.

9-2-1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: 9/3/29

20 UNDERTAKER: G. J. Beck — ADDRESS: 731 Hanover

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Sadler

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 V

CERTIFICATE OF DEATH

E 48973

REGISTERED NO. E 48973

1-PLACE OF DEATH

City of Baltimore: (No. 1617 Llewelyn St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Sadler

(a) RESIDENCE NO. 1617 Llewelyn St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Sadler

6 DATE OF BIRTH (month, day, and year) Nov 3/1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Balto, Md.

PARENTS

10 NAME OF FATHER James Sadler

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Barbara High

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto., Md.

14 Informant Geo. Ruth
(Address) Harfird & Lafayette Aves

15 Filed ....., 19..... C. HARRISON JONES, M. D.
Registrar

SEP 3 1929

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30-29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Report of Physician

(Signed) [signature] M. D.

9-2-29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Matthews Cem

DATE OF BURIAL 9/3/29

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

48974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 48974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St. 3-5 Ward)

2-FULL NAME Gretana Meo

(a) RESIDENCE NO. 211 S. Central Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Carmelo Meo

6 DATE OF BIRTH (month, day, and year) Nov-15-1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	54	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer Staff

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Jos Lonardi

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Carmelo Meo
(Address) 211 S Central Ave

15 Filed ..... 19.... SEP 3 - 1929 HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma
Stomach + knocked down & hit + Run over on 8/11/29
(duration) yrs. mns. ds.

CONTRIBUTORY (Secondary) Hepatic Neoplasm (Malignancy)
Past Febris (duration) Violent R
18 Where was disease contracted If not at place of death? Eastern Ave & Ambulance

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Frann, M. D.

(Address) 2939 Mc Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	9/3/29.
20 UNDERTAKER George J Wolfe	ADDRESS 1235 Hanford Av

Cor.—12-9-25—A Co.—200 Bks.

E 48975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48975

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hosp St. [illegible] Ward)

2-FULL NAME Daniel M. Elam

(a) RESIDENCE NO. U.S. National Cemetery St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married, Widowed~~, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Elam

6 DATE OF BIRTH (month, day, and year): 8 1864

7 AGE: Years 65; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supt of

(b) General nature of industry, business, or establishment in which employed (or employer): U.S. Nat Cem

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): unknown

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): unknown

14 Informant: Robert Brooks & Son

(Address): Calhoun & Hollins sts

15 Filed SEP 3 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsies or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Ruptured liver - struck by auto alighting from street car & passing around opposite track

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract. Extremity Pelvis

(duration) yrs. mos. ds.

(Signed) J. J. Frame M. D.

(Coroner)

9/1, 1929 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Pulaski Rd nr Hilton

Former or usual residence town

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U.S. National Cem Date of Burial 9/3 1929

20 UNDERTAKER: Robert Brooks & Son ADDRESS Calhoun & Hollins

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48976 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 48976**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 4313 Frankford Ave. ST. 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Parr

(a) RESIDENCE NO. 4313 Frankford Ave. ST.,
(Usual place of abode)

WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 a If married, widowed, or divorced (or) WIFE of John M. Parr

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Rausch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. John M. Parr

(Address) 4313 Frankford Ave

SEP 3 - 1929 Filed 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2nd 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1926 to Sept 2, 1929

that I last saw h alive on Sept 2 1929

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. Clinical

What test confirmed diagnosis?

(Signed) J S Harding, M. D.

, 19 (Address) 7810 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 5th 1929
20 UNDERTAKER	ADDRESS
Henry Koeck & Sons Inc	501 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128

E 48977

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Ward ST. 7-28 WARD)

2—FULL NAME Elizabeth Ross

(a) RESIDENCE NO. 1406 Ward ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 10 mos. 2 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaiah Ross

6 DATE OF BIRTH (month, day, and year) Oct 30 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work @ home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Dennis Creek

(Address) 1406 Ward

15 Filed SEP 3 1929, 19 HAMILTON JONES, M. D. Registrar

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS mation should be carefully supplied. AGE should OF DEATH in plain terms, so that it may be pro important. See instructions on back of certificat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-1-1929

17

I HEREBY CERTIFY, That I attended deceased from Aug-10, 19 29 to Aug 31, 19 29

that I last saw her alive on Aug 31, 19 29

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Trauma

Acute Nephritis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dan Trautman, M. D.

9/1/1929 (Address) 1122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Zion	9-4-1929

20 UNDERTAKER Joseph A. Lively

ADDRESS 1029 Monument

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48978

CERTIFICATE OF DEATH

90 E 48978

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. 4-25 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma A. Begnelle

(a) RESIDENCE NO. 657 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1775

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chambermaid.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. Y. N. Y.

PARENTS

10 NAME OF FATHER Samuel Jones

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Connors

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Ireland

14 Informant (Records of BALTIMORE CITY HOSPITALS)

(Address)

SEP 3 - 1929 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-29-29

17 I HEREBY CERTIFY, That I attended deceased from 7-19, 1929, to 8-29, 1929, that I last saw h[illegible] alive on 8-29, 1929, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Pulmonary: Hemiparesis, Left (duration) over 6 mos. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy. Exc.

(Signed) Marion W. McLean M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 3 1929
20 UNDERTAKER	ADDRESS
John C. Miller	243 E Oliver

Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 48979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

134-002

E 48979

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 938 Saratoga St. (Ward) 18-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander S. Lynn

(a) RESIDENCE NO. 938 Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Flouna Lynn

6 DATE OF BIRTH (month, day, and year) Sept 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	61	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Moving Pict. Parl.

(c) Name of employer Queen Theatre

9 BIRTHPLACE (city or town)

(State or country) Howard Co Md.

PARENTS

10 NAME OF FATHER Perry Lynn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Ann Scott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Anne Arundel Co

14 Informant Martha Diggs

(Address) 938 W Saratoga St

15 Filed ..... 19 .....

C. HAMPTON JONES, M. D.

Registrar

SEP 3 - 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 1929 to Aug 30 1929 that I last saw h[illegible] alive on Aug 29 1929 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Extravasation Urine

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Gangrene

(duration) yrs. mos. 3 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Jas L. Hooper M. D.

8/31. 1929 (Address) 812 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Cemetery	Sept 3, 1929

20 UNDERTAKER Mrs Katie R. Williams ADDRESS 325 N Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48980

91-03 E 48980

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. (ST.) 24-33 (WARD)

2—FULL NAME Geo. [redacted] Burke.

(a) RESIDENCE NO. 414 E. Fort Ave. ST., WARD 21.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 10-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	48	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John J. Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Sehley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ____, 19__ Per ____ Registrar

C. HAMPSON GIBBS M.D.

SEP 3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-29

17

I HEREBY CERTIFY, That I attended deceased from 6-21-29, 19__, to 9-2-29, 19__, that I last saw h[illegible] alive on 9-2-29, 19__ and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Thrombo-Angitis Obliterans

(duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) Gangrene

(duration) yrs 1 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 7-27-29 8-28-29

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Robert Wells, M. D.

19__ (Address) Md. Gen. Hosp. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	Sept 5 1929
20 UNDERTAKER	ADDRESS
J. M. Bullock	128 E Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS filling State Certificates OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Schneider

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48981

E 48981

CERTIFICATE OF DEATH.

124

23-31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 118 W. Clement (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie V. Schneider

(a) RESIDENCE. No. 118 W Clement St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced? HUSBAND of (or) WIFE of: Herman Schneider

6 DATE OF BIRTH (month, day, and year): July 21st 1856

7 AGE: Years 73 Months 2 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John G. Henneberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Sophia Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Sophia M. Ingham 118 W. Clement st

15 Filed SEP 3 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 25 1929, to Sept 1 1929, that I last saw h[er] alive on Aug 31 1929, and that death occurred, on the date stated above, at 6-45 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) Cholecystitis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.

Sept 1929 (Address) 3601 E. Fort Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: Sept 3rd 1929

20 UNDERTAKER: C. Schlomann & Son — ADDRESS: 1337 Hanover st

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48982

CERTIFICATE OF DEATH

44 E 48982

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 15-65 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter V Orem

(a) RESIDENCE NO. 4009 ~~Woodhaven~~ Ave (Woodhaven Ave)
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 10 mos 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C Orem

6 DATE OF BIRTH (month, day, and year) Oct 12 1878

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	10	21 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier for 409

(b) General nature of industry, business, or establishment in which employed (or employer) Stein Bro & Boyce

(c) Name of employer 6 S Calvert St

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James H Orem

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary E Forrest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs W. Irvine Orem (Address) 4009 Woodhaven ave

15 Filed SEP 3 - 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Sept 2, 1929.

that I last saw him alive on Sept 2, 1929

and that death occurred, on the date stated above, at 8 10/A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gall Bladder

(duration) yrs. 1+? mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 8/29/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) Wm D McPaul M D., M. D.

9/2, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 5 1929
20 UNDERTAKER John F Denny	ADDRESS 745 Light St

NOTE—WRITING PLAINLY. INK OR INDELIBLE PENCIL should be used. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 48983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 48983

REGISTERED NO.

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., 18-16 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Carey

(a) RESIDENCE NO. 1370 Vine St. ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? — yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Va.

PARENTS

10 NAME OF FATHER Alexander Carey

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER Amelia ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant (Records)
(Address) BALTIMORE CITY HOSPITALS

15 Filed SEP 3 1929 19 C. RAMSAY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-29

17 I HEREBY CERTIFY, That I attended deceased from 7-31, 1929, to 8-31, 1929, that I last saw h[illegible] alive on 8-31, 1929 and that death occurred, on the date stated above, at 5:25 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage, acute Pulmonary

..... (duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) Syphilis

..... (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. U.C. Lab

(Signed) Marvin M. McLaw, M. D.

8-31, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Asst. Director Health	ADDRESS SEP 3 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 48984

E 48984

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital St. 14-20 WARD)

2-FULL NAME Nina Louise Moneypenny

(a) RESIDENCE NO. 8 Leeway, Dundalk ST., Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 4 ds. How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug. 26, 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	✓	✓	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Charles H. Moneypenny

11 BIRTHPLACE OF FATHER (city or town) Ludington (State or country) Michigan

12 MAIDEN NAME OF MOTHER Annie Godbold

13 BIRTHPLACE OF MOTHER (city or town) Marion (State or country) South Carolina

14 Informant Charles H. Moneypenny (Address) 8 Leeway Dundalk Md

15 Filed SEP 3 1929 HERMON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Aug 30, 1929, that I last saw h[illegible] alive on Aug 30, 1929, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Birth Injury - Intracranial Hemorrhage

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) John B. Murray Jr., M. D.

Aug 31, 1929 (Address) 9 E. Chase Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ... 19

20 UNDERTAKER ... ADDRESS ...

Commissioner Health SEP 3 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 48985

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hosp. 24-33

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Irwin.

(a) RESIDENCE NO. 1116 William St. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/31/29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER Harry Irwin

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Mercedes Nelson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 3 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31/29.

17 I HEREBY CERTIFY, That I attended deceased from 8/31, 19 29, to 8/31, 19 29, that I last saw h[illegible] alive on 8/31, 19 29 and that death occurred, on the date stated above, at 8:[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Premature birth. - 5 months foetus.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pyelonephritis of mother

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical sign.

(Signed) M B Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: SEP 3 1929

20 UNDERTAKER .....

ADDRESS Commissioner Health.

SEP 3 1929 HARRY JONES M D

M B.—WRITE PLAINLY, WITH UNFADING INK. All items must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 48986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 48986

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St., 1-2 Ward)

2-FULL NAME Christian F. Fitzbergen

(a) RESIDENCE NO. 2909 E Balto St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Jan 18-1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	33	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Christian Fitzbergen
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto
12 MAIDEN NAME OF MOTHER Dora Bensch
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant George Fitzbergen
(Address) 2909 E. Balto St

15 Filed ..... By ..... Registrar

SEP 3 - 1929

C. HAMPSON JONES, M. D.
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract of base skull and both bones of left leg when auto he was driving struck pole (on North side of East street)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock Traumatic

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Eastern & 25th St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. J. Bauer, M. D.

9/3, 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Sept 4 1929
20 UNDERTAKER	ADDRESS
Frank V. Patterson	2815 E. Balto St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 E 48987

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3021 Fremont St. 12-51 Ward)

2-FULL NAME Morris L Boyd

(a) RESIDENCE NO. 3021 Fremont St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W.

5 ~~Single~~, Married, ~~Widowed or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret L Boyd

6 DATE OF BIRTH (month, day, and year): Feb 24th 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	56	6	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Manager
(b) General nature of industry, business, or establishment in which employed (or employer): Food
(c) Name of employer: H Sparks Food Co. Yonkers

9 BIRTHPLACE (city or town) ..... (State or country) N.Y.

PARENTS

10 NAME OF FATHER: James E Boyd

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country): New York.

12 MAIDEN NAME OF MOTHER: Annie E Lewis.

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country): New York

14 Informant: Mrs Margaret L Boyd
(Address): 3021 Fremont Ave

15 Filed ....., 19.... C. HAMPSON JONES, M. D.
Per ..... Registrar

SEP 3 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Gun Shot wound R Side Head Revolver.

(duration) 1 yrs. ... mos. 1 hr.

CONTRIBUTORY (Secondary) Shock

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What were confirmed diagnosis? —

(Signed) Dept. H. C. States, M. D.

19 (Address) 436 Derby

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudale West Lawn Cem	Sept 28 1929
20 UNDERTAKER Leo Ferdinand Gore	ADDRESS 1723 W Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 48988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 65-001 ✓

E 48988

REGISTERED NO.

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 4-30 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lewis Bradford

(a) RESIDENCE NO. Oak Grove, Delaware ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	10 11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Moritz J. Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Lester Bradford

(Address) Oak Grove Del

15 Filed SEP 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 2nd 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-28, 1929, to 9-2, 1929, that I last saw him alive on 9-2, 1929, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Myeloid Leucemia

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood picture

(Signed) Lewis P. Tandy, M. D.

9-3-1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stafford Hall	Sept 5 1929

20 UNDERTAKER W. L. Watson

ADDRESS Stafford Hall

IMPORTANT; WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—I. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48989 | E 48989

1—PLACE OF DEATH St Josephs Hospital REGISTERED NO. 76-71

CITY OF BALTIMORE: (No. Caroline St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Viola Baker

(a) RESIDENCE NO. 453 Valley View Ave WARD

(Usual place of abode) 453 VALLEY VIEW AVE

Length of residence in city or town where death occurred 38 yrs. 1 mos. 15 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm T. Baker

6 DATE OF BIRTH (month, day, and year) July 14th 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Hartlove

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Resek

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Wm T. Baker

(Address) 453 Valley View Ave

15 Filed SEP 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 29

17 I HEREBY CERTIFY, That I attended deceased from 2-16-29, 19, to 9-1-29, 19, that I last saw h alive on 9-1-29, 19 and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Pernicious Intramuscular Anemia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of no 8/31/29

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) C. Hampson Jones, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 4th 19 29

20 UNDERTAKER W Mannix Rowlson

ADDRESS 623 N Milton

B.—WRITE PLAINLY, WITH UNFADING INK. mation should be carefully supplied. AGE should be st OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48990

CERTIFICATE OF DEATH

88 E 48990

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2410 Barclay ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Fagan

(a) RESIDENCE NO. 2410 Barclay ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov-30-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment In which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Anne Arundel Co. Maryland

PARENTS

10 NAME OF FATHER: George Fagan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Maryland

12 MAIDEN NAME OF MOTHER: Ella Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? ? Maryland

14 Informant: Alda Fagan Sibb (sister)

(Address) 2410 Barclay Street

15 Filed SEP 3 1929, 19.. C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1st 29

17

I HEREBY CERTIFY, That I attended deceased from August 2, 1929, to Sept 1, 1929, that I last saw h.. alive on Sept 1, 1929 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Lenta)
(Streptococcus viridans)
(duration) Months yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Embolus
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) Chas. R. Goodwin, M. D.

, 19 (Address) 2923 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Sept 4th 19 29

20 UNDERTAKER: W M Routson

ADDRESS: 2230 W Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48991

CERTIFICATE OF DEATH

E 48991

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Poultney ST. WARD) 23-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Baumiller

(a) RESIDENCE NO. 30 Poultney ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John Baumiller

6 DATE OF BIRTH (month, day, and year) Feb 9 1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Fanny Brehm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Baumiller

(Address) 30 Poultney St

15 Filed SEP 3 - 1929, 19 ..... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from August 31, 1929, to Sept 1, 1929, that I last saw h w alive on Aug 31, 1929, and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Apoplexy.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schmuck, M. D.

19 (Address) 1337 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	9-4 1929
20 UNDERTAKER 68 E Baltimore	ADDRESS 1156 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Albert C. Goetzke

2E 8395

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

E 48992

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert C. Goetze

(a) RESIDENCE NO. 1840 Rutland Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Dora Goetze

6 DATE OF BIRTH (month, day, and year) Aug 14 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Goetze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Rader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 1 - 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3/29

17 I HEREBY CERTIFY, That I attended deceased from August 22, 1929, to Sept. 3, 1929, that I last saw him alive on Sept 3, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

~~Carbuncle Carbon~~
Carcinoma of Rectum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Cerebral Hemorrhage~~ Myocarditis

Future (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of August 29, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) George B. Finney, M. D.

Sept 3. 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cem	9-5 1929

20 UNDERTAKER Wm Chas A. G. Rehder ADDRESS 3327 Eldendorf

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 48993 HEALTH DEPARTMENT—CITY OF BALTIMORE E 48993

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutter ST. 1 3 6 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sigmund Katz

(a) RESIDENCE No. 2413 Caelard Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto- Md.

PARENTS

10 NAME OF FATHER Dank Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bernat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hosp. Records, (Address)

15 Filed . 19 Per Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/3/ 19 27.

17

I HEREBY CERTIFY, That I attended deceased from 8-15 . 19 27 . to 9-2 . 19 27.

that I last saw h in alive on 9-2-27 . 19 27

and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - 5yr

Chronic myocarditis

Diabetes mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) BJ Cohen, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohel Shalom Cy. DATE OF BURIAL 9/7/ 1927

20 UNDERTAKER Harris Sonnheim ADDRESS W. Fay. Pratt Bltg

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EP 3 - 1929

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS' should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 48994 —100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 48994

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1612 Presbury St.) (15-21 Ward)

2-FULL NAME Cora Lee Harris

(a) RESIDENCE NO. 1612 Presbury St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ollie W. Harris

6 DATE OF BIRTH (month, day, and year) May 3 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	45	3	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Jas Staley

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mollie Anderson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Lucy E Harris
(Address) 1612 Presbury St

15 Filed ..., 19... Registrar

SEP 4 - 1929 HARRY JONES, [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest and Autopsy
(Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH was as follows:

Coronary Disease
(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Leopold Adelsberg Coroner, M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL King William Co. Va

DATE OF BURIAL Sept 4 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Freestman St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 48995

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 48995

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1309 Harlem St. 16-76 Ward)

2-FULL NAME Francis M Welson

(a) RESIDENCE NO. 1309 Harlem St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fml	Col	Sngl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No,

6 DATE OF BIRTH (month, day, and year) Aug 18 - 1912

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	17	0	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waitress 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Samuel T. W.

9 BIRTHPLACE (city or town) Samuel T. W.
(State or country)

PARENTS

10 NAME OF FATHER Saml. Welson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Williams

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Anna Welson
(Address) 1309 Harlem St

15 Filed SEP 4 - 1929 HARRISON JONES, M. D. Registrar
Per Lee

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and (Inquest, autopsy, or neither) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Reginald Robbins, M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery — DATE OF BURIAL Sept 4 1929

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pennsylvania

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 48996 — 9

E 48996
REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 548 W. Mulberry St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Eubank

(a) RESIDENCE NO. 548 W. Mulberry St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14.1929

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	4	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert Eubank

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Florence Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mary Johnson
(Address) 548 W. Mulberry St.

15 Filed SEP 4 1929, 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pertussis. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia. (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eugene Zellet, M. D.

9/3, 19 29 (Address) 2139 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 3rd 1929
20 UNDERTAKER Charles Alexander	ADDRESS 1406 Gilmor St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 48997 CERTIFICATE OF DEATH E 48997

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1446 Lamman St ST. 15-21 WARD)

2—FULL NAME Baby Boy Mulligan

(a) RESIDENCE NO. 1446 Lamman St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1st 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				11 Hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) 1446 Lamman St
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert Milligan

11 BIRTHPLACE OF FATHER (city or town) Pocomoke
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Brown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mother & Father
(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,
that I last saw h... alive on Sept 1st at 11:30 A.M. 29
and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

(Premature labor and birth) Prematurity.
~~Postmature birth~~ ~~Asphyxia~~

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ...
(Secondary)
... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death? ...

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Alexander Hovey, M. D.

, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	19
20 UNDERTAKER Commissioner Health.	ADDRESS SEP 3 1929

HARRY JONES, M. D.

SEP 4 - 1929

Spec.– 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 48998

CERTIFICATE OF DEATH

113 ✓ E 48998

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13-52 WARD)

2—FULL NAME George Johnson

(a) RESIDENCE NO. 1207 Dellwood ST. Avon WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind-

PARENTS

10 NAME OF FATHER Dennis Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind-

12 MAIDEN NAME OF MOTHER Bertha Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 4 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30/29

17 I HEREBY CERTIFY, That I attended deceased from Aug-24, 1929, to August 30, 1929, that I last saw h... alive on August 30, 1929 and that death occurred, on the date stated above, at 2 15 p. m.

The CAUSE OF DEATH* was as follows:

Acute Nutritional Disturbance (Diarrhea)

Gastro Enteritis - colitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. C. Goodwin, M. D.

9/1/29 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	SEP 2 1929

20 UNDERTAKER ....

ADDRESS ....

HAMPSON JONES, M. D. Asst. Commissioner Health.

386 Filed

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

E 48999

E 48999

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-22 WARD)

2—FULL NAME James C. Jones

(a) RESIDENCE NO. 1104 Wolfcoat ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
Male	Colored	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Lewis Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emily Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 4 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28/29

17 I HEREBY CERTIFY, That I attended deceased from August 28, 1929, to August 28, 1929, that I last saw h alive on August 28, 1929 and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia & Bedsores (entero-colitis

Respiration of bowel Tbc.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) ? Tbc. Bronchopneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS SEP 3 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88

E 49000 — CERTIFICATE OF DEATH — **E 49000**

REGISTERED NO. 1876

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maggie Small

(a) RESIDENCE NO. 23 N Poppleton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jos Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Gooden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record.
(Address)

15 Filed SEP 4 - 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2/29

17 I HEREBY CERTIFY, That I attended deceased from 8/17, 1929, to 9/2, 1929,

that I last saw her alive on 9/2, 1929

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Thrombotic gangrene
left foot.

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 8/22/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

9/3, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] Cem	9-6-1929
20 UNDERTAKER Dennis Conlon	ADDRESS 916 Dr ave

N. B.—WRITE PLAINLY, WITH INDELIBLE OR FADING INK—THIS IS A PERMANENT RECORD. Every item must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49001 — REGISTERED NO. E 49001

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. [redacted] ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Lind

(a) RESIDENCE NO. 1350 N. Kelly Ave ST. 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Lind

DATE OF BIRTH (month, day, and year) Dec 24 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md. Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed SEP 4 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2-29

17 I HEREBY CERTIFY, That I attended deceased from 8-21, 1929, to 9-2, 1929.

that I last saw h[illegible] alive on 9-2, 1929

and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) Myocarditis, Cerebral Hypertension

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Aut. C.C. Law

(Signed) Marvin M. McLean, M. D.

9-3, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL Sept 6th 1929

20 UNDERTAKER Zilly + Zilli Inc — ADDRESS 403 S. Wyth St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49002 92

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 49002

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fanny Lee

(a) RESIDENCE NO. 535 - Prestman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1

6 DATE OF BIRTH (month, day, and year) ? 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 0-1

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 4 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-2/29

17 I HEREBY CERTIFY, That I attended deceased from August 22, 1929, to Sept 2, 1929, that I last saw h.e alive on Sept 2, 1929 and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic and Hypertensive Heart Disease

Myocardial Failure

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jane Bradley —, M. D.

9-3, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	9/5/29

20 UNDERTAKER Geo. H. Holland ADDRESS 1631 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 E 49003

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 16-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Long

(a) RESIDENCE NO. 22 S. Kresson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Long

6 DATE OF BIRTH (month, day, and year) Oct 9/72

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Edward Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Early

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Long (Address) 22 S. Kresson

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

SEP 4 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2/29

17 I HEREBY CERTIFY, That I attended deceased from 7/23, 1929, to 9/2, 1929

that I last saw h[illegible] alive on 9/1, 1929

and that death occurred, on the date stated above, at 1[illegible] a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma left side of mouth metastases to neck glands

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Edema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7/28/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin, M. D.

9/2, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Sept 5th 1929
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49004

CERTIFICATE OF DEATH

57

E 49004

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5916 Cedonia Av (Rosedale) ST., 12 WARD)

2—FULL NAME Augusta F. Rott

(a) RESIDENCE NO. 5916 Cedonia Av ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (or) WIFE of: Frank L. Rott

6 DATE OF BIRTH (month, day, and year): Nov 7/72

7 AGE — Years: 56 — Months: 9 — Days: 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Geo. W. Knobel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Johanna W. Ehlers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Frank L. Rott

(Address): 5916 Cedonia av

15 Filed SEP 4 1929 19 — C. HAMPSON JONES, M. D. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3/29

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to Sept 3, 1929, that I last saw h alive on Sept 3 1929 and that death occurred, on the date stated above, at 4 40 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Gangrene

(duration) yrs. 28 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. H. Volentine M. D.

(Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Sept 7 1929
20 UNDERTAKER: Philip Herwig	ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49005

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49005

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (NO. ST 15-21 WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Friedman

(a) RESIDENCE NO. 1707-3-Fulton ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Abraham Friedman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Meyer

(Address) 1713 Pennsylvania ave

15 Filed SEP 4 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 7 1929 to Sept 3 1929 that I last saw her alive on Sept 3 1929 and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
Uremia.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Dia~~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam + Lab findings

(Signed) A. S. Elser M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Sanitarium DATE OF BURIAL 9/4 1929

20 UNDERTAKER Jack Lewis 1739 E Balt ADDRESS

MARGIN RESERVED FOR BINDING

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49006

E 49006

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Lemmon ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L. Greene

(a) RESIDENCE NO. 939 Lemmon ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 2 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tracy C. Greene

6 DATE OF BIRTH (month, day, and year) June 16th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Chas A Sterling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Estelle Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Ruth A Stevens

(Address) 939 E Fort Ave.

15 Filed SEP 4 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1929, to Sept 2, 1929; that I last saw h[illegible] alive on Sept 2, 1929; and that death occurred, on the date stated above, at 10 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis.

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam etc.

(Signed) C. Washington, M. D.

9/3, 1929 (Address) 888 N Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery.	Sept 5th 1929
20 UNDERTAKER John E Conway & Son	ADDRESS 909 Lemmon St

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 49007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 E 49007

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2711 Halcyon Ave St. 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Evans

(a) Residence No. 2711 (Usual place of abode) Halcyon Ave St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie J. Evans

6-DATE OF BIRTH (month, day and year): Dec. 21, 1869

7-AGE: 59 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or mins.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: reporter for newspaper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto., Md.

PARENTS:

10-NAME OF FATHER: Frederick Evans

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Wales

12-MAIDEN NAME OF MOTHER: Harriett Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14- (Informant): Frederick E. Evans (Son)

(Address) 2711 Halcyon ave

15- Filed SEP 4 - 1929 HANSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept. 2, 1929

17- I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1929 to Sept 2 1929

that I last saw him alive on Sept. 2 1929

and that death occurred, on the date stated above, at 10.09 a. m.

The CAUSE OF DEATH* was as follows:

Septicaemia (probably streptococcic - following extraction of tooth.)

(Duration) yrs. mos. 6 ds

CONTRIBUTORY (Secondary) cardiac failure

(Duration) yrs. mos. 3 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests.

(Signed) George F. Knipp M. D.

, 19 (Address) 3036 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Sept 4 19 29

20-UNDERTAKER: Wm J Tuckner Sons

ADDRESS: Md & Pa.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49008
1-PLACE OF DEATH

E 49003
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 515 N. Vincent St. 19-27 Ward)

2-FULL NAME Jellain Jones.

(a) RESIDENCE NO. 515 N. Vincent St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no.

6 DATE OF BIRTH (month, day and year): Dec 31-1902

7 AGE: Years 26 | Months 9 | Days 2 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: maid
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Philip Jones

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Blanche Johnson

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Blanche Jones
(Address): 515 N. Vincent

15 Filed ....., 19.....

SEP 4 - 1929 BALTIMORE, MD.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 2nd 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) 1 yr. 8 mos. 21 da.

CONTRIBUTORY (Secondary) Rheumatism.

(duration) 5 yrs. 2 mos. — da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Gelbach M. D.

(Address) Coroners Office

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hope Cemetery — DATE OF BURIAL: Sept 5 1929

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS: 327 N Schroeder St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49009 E

20 E 49009

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 9-46 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John D. Lightfoot

(a) RESIDENCE NO. 2613 Boone St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Lightfoot

6 DATE OF BIRTH (month, day, and year) June 6 1910

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	19	3	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) 023
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Lightfoot

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Julia Anderson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John Lightfoot
(Address) 2613 Boone St

15 Filed ....., 19.... J. HAMPTON MOORE, M. D. Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidently struck on side of head with base ball

Cerebral Hemorrhage (duration) ..... yrs. mos. 16 hrs.

CONTRIBUTORY (Secondary) Concussion of brain

(duration) ..... yrs. ..... mos. 16 hrs.

18 Where was disease contracted if not at place of death? Druid Hill Park

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) H. G. Fisch M. D.
Sept 3 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Sept 5, 29
20 UNDERTAKER	ADDRESS
Mrs R. G. Elliott	1725 Ashland Ave

Spec.—1-12-23—M&T—500 Bks.

E 49010

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49010

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hosp.

CITY OF BALTIMORE: (No. Baltimore, Md. ST. 14 59 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Patterson

(a) RESIDENCE No. 2138 Brunt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Patterson

6 DATE OF BIRTH (month, day, and year) December 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
50				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Western Union

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER Wm Patterson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore
12 MAIDEN NAME OF MOTHER Anderson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alice Patterson
(Address) 2138 Brunt St

15 Filed 9/2/1929 WILLIAM R. JONES, M. D. Registrar

SEP 4 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-2 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1929, to Sept 2, 1929, that I last saw h[illegible] alive on Sept 2 - , 1929 and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Carcinoma
Ante Coronatoris

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis & Nephritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 2-1929

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Findings Satisfactory

(Signed) J. Vallarino, M. D.

, 19 (Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn cem. — DATE OF BURIAL Sept 4, 1929

20 UNDERTAKER Mrs. R. A. Elliott — ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Mack Lee

E 49011 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 Ashland Ave ST. 10-14 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mack Lee

(a) RESIDENCE No. 827 Ashland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) D. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown.

14 Informant Clara Mahoney
(Address) 827 Ashland Ave.

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D.
Registrar

SEP 4 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 1 - 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 26 . 1929 to Aug 31 . 1929.

that I last saw him alive on Aug 31 . 1929.

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

(duration) yrs. 1 mos 1 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) O. G. Hornstein, M. D.

9/3 . 1929 (Address) 733 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 4 1929
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1720 Ashland

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49012 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49012

1-PLACE OF DEATH President Hospital

CITY OF BALTIMORE: (No. 14-20 ST. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazella Matthews

(a) RESIDENCE NO. 11½ College Ave ST. Annapolis Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) June 15, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Dennis Murdock

11 BIRTHPLACE OF FATHER (city or town) (State or country) A-A-Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis A-A-Co Md

14 Informant Edgerton Matthews (Address) 11½ College ave

15 Filed SEP 4 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-3-29, 19 , to 9-3, 19 29, that I last saw her alive on 9-3, 19 29, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Dystocia

Duration for only 36 hours before entering hospital. Patient died during preparation for Caesarean (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did operation precede death? Yes Date of 9/3/29

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) H. B. Butler, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Mt. Moriah Cem.

DATE OF BURIAL Sept 5 19 29

20 UNDERTAKER E H Parker

ADDRESS 47 Washington

51

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49013

CERTIFICATE OF DEATH.

47 E 49013

REGISTERED No. 26-42

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4703 Hazlewood Ave. WARD)

2-FULL NAME Alice Virginia Green

(a) RESIDENCE No. 4703 Hazlewood Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Green

6 DATE OF BIRTH (month, day, and year) Nov. 12-1857

7 AGE	Years	Months	Days 21	If LESS than 1 day, ... hrs. or .... min.
	72	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph H. Amey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ellen Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Arthur Appler

(Address) 4703 Hazlewood Ave.

15 Filed SEP 4 - 1929 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1929

17

I HEREBY CERTIFY, That I attended deceased from winter of 1925 to Sept. 3 1929.

that I last saw her alive on Sept. 2 1929.

and that death occurred, on the date stated above, at 12.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 6 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? Yes Date of 1923

Was there an autopsy? no

What test confirmed diagnosis? ———

(Signed) G. M. Bacon M. D.

9/3 1929 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 5 1929
20 UNDERTAKER	ADDRESS
George J. Smith	133 Hollins

Spec.—1-12-23—M&T—500 Blks.

E 49014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 49014

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital ST., 20 WARD)

REGISTERED NO. 29-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Gorham

(a) RESIDENCE NO. 11 South Caroline ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	A.A.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Robert L. Gorham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address)

15 Filed SEP 4 1929, 19 C. HAMPSON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1929

17

I HEREBY CERTIFY, That I attended deceased from 9-1, 1929. to 9-3, 1929.

that I last saw him alive on 9-, 1929.

and that death occurred, on the date stated above, at 8:30P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Primary

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Wallace, M. D.

9/4, 1929 (Address) President Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tillery North Carolina

DATE OF BURIAL 9/6 1929

20 UNDERTAKER Edmonds Funeral Home

ADDRESS E. 31.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 49015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 E. Chase ST., 7-13 WARD)

2—FULL NAME Baby Baltenhauser

(a) RESIDENCE NO. 1909 E Chase St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Baltenhauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frances Bundy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant R. G. Douglas

(Address) Johns Hopkins Hospital

15 Filed SEP 4 1929, 19 38 AM

JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 19 29, to Aug. 22, 19 29

that I last saw her alive on Aug. 22, 19 29

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. G. Douglas, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Sept 19

20 UNDERTAKER

ADDRESS

N. B.—WHITE PLAINLY, WITH PEN AND INK. THIS IS A PERMANENT RECORD. EACH ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in filling CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 49016 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49016

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3016 Gibbons ave St.) (WARD) 27-44

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Gantt

(Residence in Baltimore: No. 3016 Gibbons Ave Hamilton St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	S

6-DATE OF BIRTH, Sept- 3rd. 1929, 1 (Month) (Day) (Year)

7-AGE, ...yrs....mos....da. If LESS than 1 day, ...hrs. or 1 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, George Gantt

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Marion Kleintank

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Marion Gantt
(Address) 3016 Gibboms Ave.

15-
Filed ....., 191.... C. HAMPSON JONES, M. D.
SEP 4 - 1929 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3rd 1929 Sept 3 (Month) (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1929, to Sept- 3rd. 1929, that I saw her alive on Sept- 1929, and that death occurred, on the date stated above, at 4-1 P. m.

The CAUSE OF DEATH* was as follows:

Faulty Presention
Strangulation at Birth
(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) ....
(Duration) ....yrs. ....mos. ....da.

(Signed) [illegible] M. D.
Sept 4, 1929 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Hill Park — DATE OF BURIAL, Sept 4, 1929

20-UNDERTAKER Morton W. E. Offutt — ADDRESS 57 S. Amer St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 49017. HEALTH DEPARTMENT—CITY OF BALTIMORE. E 49017

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 413 N. Smallwood St.: 20-69 (Ward) (REGISTERED NO.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sophia Rosenmann

(a) RESIDENCE. No. 413 N. Smallwood St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Rosenmann

6 DATE OF BIRTH (month, day, and year) Nov. 17-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Redmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr. Louis Rosenmann (Address) 829 Park Ave.

15 Filed SEP 4 - 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929 to Sept 3, 1929, that I last saw h[e] alive on Sept 2, 1929, and that death occurred, on the date stated above, at 5.50 a.m.

The CAUSE OF DEATH* was as follows: Acute Pleurisy (Catarrhal)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. G. Dill M. D.

(Address) 1509 W. Lombard St. 9-4, 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 5 1929

20 UNDERTAKER George L. Schwab ADDRESS 2101 Druid

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. If none, or not known, so state. PHYSICIANS: Cause of death must be stated EXACTLY. AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10.20

Cor.—10-10-29—A Co.—100 Bks.

E 49018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49018

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Agnes Hosp St. 25-10 Ward)

2-FULL NAME Albert Allder Heacock

(a) RESIDENCE NO. Dulaney Valley R F D 2nd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Co
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co
(State or country)

PARENTS

10 NAME OF FATHER Frank E. Heacock

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hamer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Frederick Co

14 Informant Mary E. Heacock
(Address) Phoenix, R. F. D.

15 Filed SEP 4 1929, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis following fracture of Dorsal Vertebrae
(Accident)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Donovan M. D.

9/4, 1929 (Address) 3601 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Lawn Cemetery	Sept 6 1929
20 UNDERTAKER	ADDRESS
John Burns Sons Greenmount	Towson Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49019 90 E 49019

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 27-43

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Lewis Pickton

(a) RESIDENCE NO. 302 Hamilton Ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records (Address)

15 Filed APR 4 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/30/29

17 I HEREBY CERTIFY, That I attended deceased from 6-21, 1929, to 8-30, 1929.

that I last saw him alive on 8-30, 1929

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis, chronic

Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harvey M. McLean, M. D.

9-1, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	9/4, 1929
20 UNDERTAKER John J. Fahey Sons	ADDRESS 1318 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49020

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

1929 **E 49020**

REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Natale Astin

(a) RESIDENCE NO. 402 E. Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) March 15, 1845

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
5-4	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Biaggio Astia

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER L. Torri

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant L. Torri

(Address) 902 E. Pratt

15 Filed Sept 6 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 4 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull

Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Sept 4, 1929 (Signed) W. J. Fahey (Coroner) M. D.

(Address) 1639 Bruadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial Sept 6 1929

20 UNDERTAKER Frank V. Pepitone — ADDRESS 2518 E Pratt St

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

P 4

Spec—12-23-21—E.B.R.S.—400 Bks.

E 49021 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~1306~~ 1307 Madison Ave Ward) 11-24 162

Registered No.

2-FULL NAME Infant Johnson

(a) Residence No. ~~1306~~ 1307 Madison Ave St., Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. Col.

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 9-2-29

7-AGE, 0 yrs. 0 mos. 1 ds. If LESS than 1 day, 8 hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Arthur Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Edith Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md.

14- (Informant) Thelma Johnson

(Address) 1306 Madison Ave

15- Filed SEP 5 1929 HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 9-3-29

17- I HEREBY CERTIFY, That I attended deceased from 9-2-29, 19 to 9-3, 19 29, that I last saw ~~living~~ alive on 9-2, 19 29, and that death occurred, on the date stated above, at 2 00 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) /

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Wales Williams M. D.

9-3, 1929 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

[illegible] CREMATION, OR REMOVAL. DATE OF BURIAL. Sept 5 1929

20-UNDERTAKER. Samuel T. Henby ADDRESS 678 N Bond St

18—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001

E 49022

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rev. Clarence E. Wheeler

(a) RESIDENCE NO. Holy Comforter ST., Church WARD Washington D.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Butte Mont.

PARENTS

10 NAME OF FATHER Bennet Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Harriett Welty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Sophia M. Wheeler

(Address) Washington D.C.

15 Filed SEP 5 - 1929 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 1 1929 to Sept 5 1929

that I last saw h in alive on Sept 4 1929

and that death occurred, on the date stated above, at 8 20 A.M.

The CAUSE OF DEATH* was as follows:

Abscess of brain

(duration) yrs. 5 mos. 10 ds.

CONTRIBUTORY (Secondary) Abscess of Lung

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Wash. D. C.

Did an operation precede death? Yes Date of May 1929

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Thos. E. Stacy Jr. M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL 9/5 1924

UNDERTAKER Chas. S. Davis & Son

ADDRESS Mt Royal

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Any mistake or omission should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49023

REGISTERED NO. 12 E 49023

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Hanford Rd ST. 27-43 WARD)

2-FULL NAME Francis Voight

(a) RESIDENCE NO. 5106 Hanford Rd ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Voight

6 DATE OF BIRTH (month, day, and year): Aug 3 - 1863

7 AGE — Years: 66 — Months: 1 — Days: — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Forbearer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mrs Zahel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Dr. Herman Voight 5106 Hanford Rd.

15 Filed SEP 5 1929 C. HAMPSON JONES, M. D., Registrar. By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-3 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 29th, 1929, to Sept 3rd, 1929, that I last saw h[illegible] alive on Sept 3rd, 1929, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs mos 14 ds.

CONTRIBUTORY (Secondary): Acute Cholecystitis

(duration) yrs mos 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy, M. D.

(Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 9-6 1929

20 UNDERTAKER: Leonard J. Rank

ADDRESS: 649 Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49024 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49024

REGISTERED NO.

1—PLACE OF DEATH Bacto City Hosp. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Bacto 3rd ST 26-41 WARD)

2—FULL NAME Henry Seelye

(a) RESIDENCE NO. 4131 Mary Ave ST. Belair Rd, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1y yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearle Seelye

6 DATE OF BIRTH (month, day, and year) Nov 3 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) Bacto City Hosp.

15 Filed SEP 5 1929, 19 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-29

17 I HEREBY CERTIFY, That I attended deceased from 11-26-, 1928 to 9-3, 1929

that I last saw him alive on 9-3, 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical findings

(Signed) Harry Friedman M. D.

9/4, 1929 (Address) Williams & Bayard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	9-4 1929
20 UNDERTAKER	ADDRESS
H. O. Brown	Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49025

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49025
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 307 E. Lafayette Ave ST., 19-14 (WARD)

2-FULL NAME Lawrence V. Finnegan

(a) RESIDENCE NO. 307 E. Lafayette Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Susie F. Finnegan

6 DATE OF BIRTH (month, day, and year) Feb 14 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer P. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS
10 NAME OF FATHER Bernard Finnegan
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Mary Morgan
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant L. Finnegan
(Address) 307 E. Lafayette Ave

15 Filed SEP 5 - 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 , 1929 , to Sept 3 , 1929 , that I last saw him alive on Sept 3 , 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Old age
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Towns, M. D.
, 19 (Address) 4149 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmt. Cath. Cem. — DATE OF BURIAL 9-7 1929

20 UNDERTAKER L. J. Rude — ADDRESS 640 Saratoga

MARGIN RESERVED FOR BINDING

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 49026

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49026

CERTIFICATE OF DEATH.

Registered No. 5-8 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 426 N. Front St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Stitt

(a) Residence No. 426 N. Front St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1894

7-AGE. 35 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer). Home

(c) Name of employer. Home

9-BIRTHPLACE (city or town) (State or Country). Watertown N. Y.

PARENTS.

10-NAME OF FATHER, J. A. Stitt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Watertown N. Y.

12-MAIDEN NAME OF MOTHER, Sarah Knauss

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Watertown N. Y.

14- (Informant). Mrs. Harrington

(Address) 706 E. Preston

15- Filed SEP 5 - 1929

C. HANSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-2-29

17- I HEREBY CERTIFY, That I attended deceased from Aug 14, 19 29 to Sept 2, 19 29

that I last saw h alive on Sept 2, 19 29

and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John Parke M. D.

Sept 3, 19 29 (Address) 1936 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cemetery DATE OF BURIAL. Sept 5, 19 29

20-UNDERTAKER. Elmer W. Conklin ADDRESS 924 E Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1855 E 49027

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 13-59 Ward)

2-FULL NAME Benjamin Hamburger

(a) RESIDENCE NO. Whitepark Apts. St., Ward
(Usual place of abode)

Length of residence in city oc town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married.

5a If married, widowed, oc divorced
HUSBAND of
(or) WIFE of Jennie Van Leer Hamburger

6 DATE OF BIRTH (month, day, and year)
June 29, 1864.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	65	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, pcofession or particular kind of work Packer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Manes Hamburger

11 BIRTHPLACE OF FATHER (city or town)
(State or countcy) Germany

12 MAIDEN NAME OF MOTHER
Caroline Nathan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Jennis Hamburger
(Address) Whitepark Apts.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrac

SEP 5 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/3/29. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thercon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fractured Skull.
Accidental Death.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) [redacted]

O.K. E.Z.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted? If not at place of death? Foot of Lakewood Av
Did an operation pcecede death? Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Eugene Zellert, M. D.
9/4/ 1929 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See ceverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ohel Shalom Cem	9/5/1929
20 UNDERTAKER Klaid Sondheim	ADDRESS 1420 W. Mt. Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49028

CERTIFICATE OF DEATH

129

E 49028

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST., 11-24 WARD)

2—FULL NAME Mary S. Roberts

(a) RESIDENCE NO. 1313 Hackney Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Femal	Colored	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ezekiel Roberts

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt presser

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John B. Dungee

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) unknown

14 Informant Mrs Julia Dungee
(Address) 1338 Druid Hill ave

15 Filed ..... 19 ..... C. HAMPSON JONES ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 2 1929

17 I HEREBY CERTIFY, That I attended deceased from August 22 1929 to Sept 2 1929

that I last saw h[illegible] alive on Sept 2 1929

and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiovascular disease, valvular disease of heart, myocardial insufficiency, heart failure

Chronic Nephritis (duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ..... yrs. ..... mos. 3 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	9-5- 1929
20 UNDERTAKER	ADDRESS
Mrs Edna G. Bailey	1421 Jefferson St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 5 1929 C. HAMPSON JONES

Cor.—10-10-29—A Co.—100 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49029
1-PLACE OF DEATH

E 49029
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 514 Asbury Ct. St., 18-26 Ward)

2-FULL NAME Annie Byrd

(a) RESIDENCE NO. 514 Asbury Ct. St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Washington Byrd

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE: Years 64 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Va.
(State or country)

PARENTS

10 NAME OF FATHER: Jeremiah Myers

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Washington Byrd
(Address): 514 Asbury Ct

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

SEP 5 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular Medical

Sept 5 19 29 (Signed) [illegible] M. D. (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 7, 1929
20 UNDERTAKER	ADDRESS 321 N Schroeder St
Mrs. Kate R. Williams	

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49030

CERTIFICATE OF DEATH

1975

E 49030

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., 15-23 Ward)

2-FULL NAME Sammy Hall

(a) RESIDENCE NO. 1357 N. Bunny St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unk

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unk

14 Informant John Butler
(Address) 1922 Druid Pk

15 Filed SEP 5 - 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 31 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy and inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicide
General Sepsis
& Emphysema.
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (Pistol wound of Chest)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of August 1st

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Chas Smith M. D.
Coroner
(Address) Sept 12

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winston Salem N. C	Sept 5 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Preston

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Byerly 3048 W. North Ave

E 49031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 49031

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 801 Dukeland ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robt J Moorehead

(a) RESIDENCE NO. 801 Dukeland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Moorehead

6 DATE OF BIRTH (month, day, and year) Mar 17th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Kelly Springfield Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Thos Moorehead

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary Hartree

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Louis A. Rand

(Address) 217 N. Charles st

15 Filed SEP 5 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1929, to Sept 3rd, 1929, that I last saw h~~im~~ alive on Sept 3rd, 1929, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Nephritis - arteriosclerosis

Senility -

Carcinoma with metastases (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. P. Byerly, M. D.

, 19 (Address) 3048 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 6th 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Bishop Sheridan & York Roads

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49032

CERTIFICATE OF DEATH

101-001

REGISTERED NO. E 49032

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5902 York Road ST.) 27-48 WARD

2—FULL NAME John T Walker

(a) RESIDENCE NO. 5902 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Walker

6 DATE OF BIRTH (month, day, and year) April 5th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	29	8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer (Butter & Eggs)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John T. Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth McCracken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Mary E. Walker

(Address) 5902 York Road

15 Filed ..... 19 .....

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Sept 3, 1929, that I last saw him alive on Sept 3, 1929 and that death occurred, on the date stated above, at 9.05 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia

Acute Cholecystitis

Ch DS. Nephritis - Ch Myocarditis

(duration) yrs. mos. 10 da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) B. W. Bishop, M. D.

Sept 4, 1929 (Address) 502 Sheridan Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	9/6 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 15 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49033

CERTIFICATE OF DEATH

74001

E 49033

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 S Howard ST., 23-31 WARD)

2—FULL NAME Frances Dobson

(a) RESIDENCE NO. 1033 S. Howard ST., 23 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Richard Dobson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary F. Johnson

(Address) 1033 S Howard St.

15 Filed SEP 5 1929, 19

C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/3/29

17 I HEREBY CERTIFY, That I attended deceased from 8/29/29, 19 29, to 9/3/29, 19 29 that I last saw her alive on 9/3/29, 19 29 and that death occurred, on the date stated above, at 6:00 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (Primary or Immediate)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

9/5, 19 29 (Address) 908 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	Sept 6 1929
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	108 W. Mond

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49034 | 1851 | E 49034

1-PLACE OF DEATH

City of Baltimore: (No.) Md Gen Hosp. St. 22-30 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos B. Freesman

(a) RESIDENCE NO. 690 Wash Blvd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Freda B Freesman

6 DATE OF BIRTH (month, day, and year): Nov 20 1881

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47	9	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lumber Salesman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER: Bernard Freesman

11 BIRTHPLACE OF FATHER (city or town): Germany
(State or country)

12 MAIDEN NAME OF MOTHER: Theresa Thumm

13 BIRTHPLACE OF MOTHER (city or town): Germany
(State or country)

14 Informant: Freda B Freesman
(Address) 3002 E Fayette

15 Filed SEP 5 - 1929 19 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3rd 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Fell on floor
Acute Nephritis
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Fractured L. Shoulder
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 690 Wash Blvd

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Reggling Hollerith M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Sept 6 1929
20 UNDERTAKER	**ADDRESS**
Mrs. John W. Teufel & Son	504 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 49035 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131 E 49035

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 20-71 WARD)

2-FULL NAME Miss Margaret O'Conor

(a) RESIDENCE No. 16 N. Augusta Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs -- mos -- ds. How long in U. S., if of foreign birth? -- yrs -- mos -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 24, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER John O'Conor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Doyle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Anna O'Conor
(Address) 16 N Augusta Ave

15 Filed SEP 5 1929 H. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-1929.

17 I HEREBY CERTIFY, That I attended deceased from 8-20, 1929, to 9-3, 1929, that I last saw her alive on 9-3, 1929, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Policystetes Kidney

Probably Congenital
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative Nephritis
Uraemia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At her home

Did an operation precede death? Yes Date of 8/30/29

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Autopsy

(Signed) Nicholas J. Bonelli, M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Joseph's Cem. Texas

DATE OF BURIAL: 9/6 1929

20 UNDERTAKER: Henry A. Mears & Son

ADDRESS: 405 N Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

REGISTERED NO. E 49036

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 624 Conway ST. 22-30 (WARD)

2—FULL NAME Thelma Bryant

(a) RESIDENCE NO. 624 Conway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1910

7 AGE: Years 19 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lillie Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Clara Bryant
(Address) 624 Conway St

15 Filed SEP 5 - 1929 19 C. HAMPSON GIBBONS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/3/29

17 I HEREBY CERTIFY, That I attended deceased from July 1 19 29 to Sept 3 19 29

that I last saw h alive on Sept 3 19 29

and that death occurred, on the date stated above, at 3 55 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Hoffmann

(duration) yrs mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Diamond M. D.

19 (Address) 4 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem DATE OF BURIAL: Sept 5 29

20 UNDERTAKER: Samuel P. Kemsley ADDRESS: Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49037

45

CERTIFICATE OF DEATH

E 49037

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1946 W Lafayette ST. 16-23 WARD)

2—FULL NAME Emma Sternad

(a) RESIDENCE NO. 1946 W Lafayette Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Sternad

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Prayl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Sternad

(Address) 1946 Lafayette Ave

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

Per

SEP 5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1929, to Sept 4, 1929, that I last saw her alive on Sept 4, 1929 and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(Probable Malignant Origin)

9 (duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Agustus Dill M. D.

9/5, 1929 (Address) 1509 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Sept 7th 1929
20 UNDERTAKER Charles W. Dill.	ADDRESS 3109 Fredk Ave.

Information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 49038

REGISTERED NO. E 49038

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Harris

(a) RESIDENCE NO. Sinai Hospital ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Male~~ ~~Female~~	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Frank Harris

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Yetta Harris

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant
(Address)

15 Filed SEP 5 1929 19 Register C. HAMPSON JONES, M. D. JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 1929, to Sept 2, 1929, that I last saw him alive on Sept 2, 1929, and that death occurred, on the date stated above, at 12 05 A m.

The CAUSE OF DEATH* was as follows:

Premature Baby

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Melin Radmen, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Aug 29 1929

20 UNDERTAKER

ADDRESS

Commissioner Health.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49039 ✓ E 49039

CERTIFICATE OF DEATH

118-002

1-PLACE OF DEATH

City of Baltimore: (No. 1505 N. Mount St., 15-21 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris L. Smith

(a) RESIDENCE No. 1505 N. Mount St. Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Ascension Hall

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Nannie Smith

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Nannie Smith
(Address) 1505 N. Mount

15 Filed SEP 5 1929 19 C. HAMPSON JONES, M. D. Registrar

3879

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an _____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction (duration) yrs. mos. 1 ds.

CONTRIBUTORY _____ (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leech M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Aug 5 1929
20 UNDERTAKER	ADDRESS
Department of Health.	

P. W. E. WOODALL

Sp... 12-[illegible] ...0 Blks.

E 49040 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 49040**

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 Small St. 9-14-29 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Smith Gill

(a) RESIDENCE NO. 701 Small St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/20/29

7 AGE — Years | Months: 6 | Days: 16 | IF LESS than 1 day.....hrs. or.....min. 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Arthur Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Bessie Montgomery

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Bessie Smith

(Address) 701 Small St

15 [illegible] 19

1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14/29

17

I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept [illegible], 1929

that I last saw him alive on Sept 3, 1929

and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Acute Toxemia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis about 4

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) John H. Thompson, M. D.

9/15/29 (Address) 1512 N Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem Date of Burial 9-5 1929

20 UNDERTAKER: George T. H. Gibbs ADDRESS 735 Lewis Hilton

P 5

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49041

REGISTERED NO. 1290

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3005 Woodland Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Elizabeth Eckert

(a) RESIDENCE NO. 3005 Woodland Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Geo W Eckert

6 DATE OF BIRTH (month, day, and year) May 31st 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Alexander Davis

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Laura Redden

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Alex Davis
(Address) 3005 Woodland Ave

15 Filed SEP 5 - 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to Sept. 3, 1929
that I last saw her alive on Sept. 3, 1929
and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation
Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What tests confirmed diagnosis? Phys. Examination

(Signed) Charles L. Bagott M. D.

, 19 (Address) 1015 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 9/6 1929

20 UNDERTAKER D. Wm Cook

ADDRESS 1217 St Paul St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49042

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 490+2

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 76-4B WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Landes

(a) RESIDENCE NO. 310 North Point Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Noah Landes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lindia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record

(Address)

15 Filed ..., 19 Registrar

FEB 5 1929

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4/29

17

I HEREBY CERTIFY, That I attended deceased from 8/19, 1929, to 9/4, 1929, that I last saw him alive on 9/4, 1929 and that death occurred, on the date stated above, at 3 45 a. m.

The CAUSE OF DEATH* was as follows:

~~Hemiplegia right side~~

Arteriosclerosis,

Paralysis of right side of body

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Acute Cerebral Hemorrhage

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Lumpkin, M. D.

2/4, 1929 (Address) Balto. City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisonburg Va	9/6 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 E Baltimore St

Information should be carefully supplied. Age should be stated in years, months, days, or hours, as may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49043

CERTIFICATE OF DEATH

X 129

E 49043

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4-7 WARD)

2—FULL NAME Joseph Samone

(a) RESIDENCE NO. Texas Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	5	20	16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Samone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Samone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary Samone

(Address) [illegible]

15 Filed SEP 5 - 1929, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Sept 5, 1929

that I last saw him alive on Sept 5, 1929

and that death occurred, on the date stated above, at 10 20 A. m.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Convulsions CV disease

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J J Leyko M. D.

Sept 5, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Joseph, Texas, Balto. Co.

DATE OF BURIAL Sept 7 1929

20 UNDERTAKER [illegible]

ADDRESS Spark's Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49044 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49044

90

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1321 Eldon Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Stallings, Sr.

(a) RESIDENCE NO. 1321 Eldon Ave ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. — mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Stallings

6 DATE OF BIRTH (month, day, and year) Aug. 6-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired 12 years

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Stallings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah E. Offendall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Minnie Stallings

(Address) 1321 Eldon Ave.

15 Filed SEP 5 1929, 19.. Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4-1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to Sept. 4, 1929

that I last saw him alive on Sept. 4, 1929 at 1 A. m.

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

Chronic Nephritis (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Hurd, M. D.

19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept. 7, 1929
20 UNDERTAKER	ADDRESS
Horace H. Burgee	431 Falls Road

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 49045

E 49045

CERTIFICATE OF DEATH Sazewic

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 21-29 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Sackowich. [Geo. Sazewic

(a) RESIDENCE NO. 1820- Mungold ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Pick & shovel

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Sackowich

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Poland

14 Informant Records
(Address) BALTIMORE CITY HOSPITALS

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) P-31-29

17 I HEREBY CERTIFY, That I attended deceased from 7-27, 19 29, to P-31, 19 29, that I last saw h... alive on P-31, 19 29 and that death occurred, on the date stated above, at 9 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic.

over 2 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypertension.

over 1 (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ass't. C. Law. Exam

(Signed) Marvin M. McClain, M. D.

P-31, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	9/5/29

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO... important. See instructions on back of certificates.

ER 5 1929

Spec.—2-29-28—L. F. S.—500 Bks.

(Malkmus)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49046

44 E 49046

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 N Bentalou ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Malkmus

(a) RESIDENCE NO. 28 N Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Malkmus

6 DATE OF BIRTH (month, day, and year) March 7, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardwood Finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Malkmus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Baty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Malkmus

(Address) 28 N Bentalou St

15 5 - 1929 C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1929, to Sept 4, 1929.

That I last saw him alive on Sept 3, 1929

and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease.

(duration) over two months, yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of the liver

(duration) over 2 months yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Hist.

(Signed) Henry C. Bible, M. D.

4-5, 1929 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	9/7 1929
20 UNDERTAKER George A. Fahy Funeral	ADDRESS Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO... important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49047 2285364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 45

E 49047

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-4 WARD)

2—FULL NAME Charles Flood

(a) RESIDENCE NO. Belairs Mills Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Manda

6 DATE OF BIRTH (month, day, and year) 10-3-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Henry Flood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Matilda Briggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 5-1929, By C. HAMPSON JONES, M. D. Registrar

P

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-5-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1929, to Sept 5, 1929, that I last saw him alive on Sept 5, 1929 and that death occurred, on the date stated above, at 5.50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum, post-operative (date 8/1)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 8 27 29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & autopsy

(Signed) Clarence E Gardner Jr. M. D.

9/6, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Pa	9/5/29
20 UNDERTAKER Joseph Akers	ADDRESS 221 Bway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49048

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49048

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 ST. (or WARD) W. Baltimore

REGISTERED NO. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.) BALTIMORE CITY HOSPITALS

2—FULL NAME Bernard Malone ?

(a) RESIDENCE NO. ? ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of ?
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-3-65

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) N. Y.
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Lawrence Malone

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine McCafferty

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Ireland

14 Informant Records of BALTIMORE CITY HOSPITALS
(Address)

15 Filed C. HAMPSON JONES, M. D. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-29

17 I HEREBY CERTIFY, That I attended deceased from 6-27, 1929 to 8-31, 1929.

that I last saw him alive on 8-31, 1929

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Acute

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis, chronic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

9-1, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Bureau of Vital Statistics

ADDRESS 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

5 1920

Spec.—2-29-28—L. F. S.—500 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 49049 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49049

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ST., WARD)

BALTIMORE CITY HOSPITALS

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Thomas

(a) RESIDENCE NO. ? ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Wash., D. C.

PARENTS

10 NAME OF FATHER Benjamin Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed SEP 5 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-1-29

17 I HEREBY CERTIFY, That I attended deceased from 10-17, 1929, to 9-1, 1929, that I last saw h. alive on 9-1, 1929 and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Aut. PC

(Signed) Marvin M. McLean, M. D.

9-1, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER Commissioner Health	ADDRESS SEP 5 1929

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49050

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 14-27 WARD)

2—FULL NAME Bertie Tucker

(a) RESIDENCE NO. 519 N. Stricker ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? — yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?
(State or country) Md.

PARENTS

10 NAME OF FATHER Steve Young

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ~~Md.~~ ?

12 MAIDEN NAME OF MOTHER Sarah Robinson

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant Records of
(Address) UNIVERSITY OF MARYLAND

15 Filed 1929 19 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-29

17

I HEREBY CERTIFY, That I attended deceased from 5-22-29, 19..., to 9-3, 19 29, that I last saw h. alive on 9-3, 19 29 and that death occurred, on the date stated above, at 8 20 P m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Wass. & C.

(Signed) Warren M. McLean, M. D.

9-5, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	SEP 5 1929
20 UNDERTAKER	ADDRESS
[illegible] Health.	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49051

HEALTH DEPARTMENT—CITY OF BALTIMORE

35

E 49051

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gilbert Dixon

(a) RESIDENCE NO. 1006 Eutaw ST., WARD
(Usual place of abode) ?
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER Samuel Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

14 Informant Hospital Record

(Address) UNI

15 Filed 19 3885 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/3/29

17 I HEREBY CERTIFY, That I attended deceased from 4/23, 1929, to 9/3, 1929, that I last saw him alive on 9/3, 1929, and that death occurred, on the date stated above, at 7 P. a. m.

The CAUSE OF DEATH* was as follows:

Chronic arthritis right hip joint

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Longbein, M. D.

9/3, 1929 (Address) Balt. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNIVERSITY OF MARYLAND

19

20 UNDERTAKER — ADDRESS

Sep 5 1929

Commissioner Health.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49052

CERTIFICATE OF DEATH

X 44 E 49052

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital St. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pedro Santos

(a) RESIDENCE NO. Rio de Janeiro Janeiro ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 49 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Deck Hand

(c) Name of employer S.S. Pierre Pocono

9 BIRTHPLACE (city or town) (State or country) Rio de Janeiro

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant —

(Address) —

15 FILED SEP 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31/29

17 I HEREBY CERTIFY, That I attended deceased from 8/26, 1929, to 8/31, 1929, that I last saw him alive on 8/31, 1929, and that death occurred, on the date stated above, at 45 m.

The CAUSE OF DEATH* was as follows: Generalized Carcinomatosis Aortic & Mitral insufficiency Myocarditis, (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical examination

(Signed) Louis P. Gundry, M. D.

9-5, 1929 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Sept 5 1929

20 UNDERTAKER: Harry A. Welsh — ADDRESS: 1531 W Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49053 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH X 31 E 49053

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. H-7 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilbur Smith

(a) RESIDENCE NO. 540 Broadway (Usual place of abode) ST. Hanover, Pa. WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19/12

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17		16 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover, Pa.
(State or country)

PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Philomina Nail.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Chas E. Smith
(Address) Hanover Pa.

15 Filed SEP 5 1929 19 C. HAMPSON JONES M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5/29

17

I HEREBY CERTIFY, That I attended deceased from 8/[illegible]/29, 19..., to 9/5/29, 19...

that I last saw him alive on 9/5/29, 19...

and that death occurred, on the date stated above, at 9 30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
a/ Pulmonary
b/ Joint

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 5/10/29

Was there an autopsy? No 6/20/29

What test confirmed diagnosis? X Ray - Lumbar Puncture

(Signed) David Zeiser, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hanover Pa.	Sept 7 1929
20 UNDERTAKER W. A. Feiser	ADDRESS Hanover Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49054 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 E 49054

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1415 Linden Av ST. 4-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Waller Howard Webb

(a) RESIDENCE NO. 1415 Linden Av. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 2 mos 11 ds. How long in U. S., if foreign birth? 70 yrs. 2 mos 11 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June 24 1859

7 AGE — Years: 70 Months: 2 Days: 11 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): B. O. R.R.

(c) Name of employer: B. O. R.R. Co.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Geo. F. Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Georgianna Telford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Wm. F. Q. Lewenig Jr. Trustee (Address) 364 Hendrix Road

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1929.

17 I HEREBY CERTIFY, That I attended deceased from ....., 1925, to Sept 4, 1929

that I last saw him alive on Sept 4, 1929

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Terminal

(Signed) Standish McAllister, M. D.

(Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Sept 6 1929

20 UNDERTAKER: Stewart Homer Co — ADDRESS: Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49055

REGISTERED NO. E 49055

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clinton Fields.

(a) RESIDENCE NO. 2010 Gold Spring Ln. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE: Years 36 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Richmond
(State or country): Va

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Jas F Smith
(Address): 2010 Gold Spring Ln

15 Filed ... 19..

P C - 1929 C. HAMPSON JONES, M.D. Registrar

Per ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident Burn matches Caught fire. setting fire to clothes) 2nd degree burns (duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2010 Gold Spring Ln

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leitch Jones M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: Sept 6 1929

20 UNDERTAKER: Joseph A Lively — ADDRESS: 4093 Mont Ave

PENALTY—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49056 HEALTH DEPARTMENT—CITY OF BALTIMORE

94-002

CERTIFICATE OF DEATH

E 49056

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 N. East ave ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George A. Kramer

(a) RESIDENCE NO. 420 N. East ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Kramer

6 DATE OF BIRTH (month, day, and year) Jan 2, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired. 624

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Geo W. Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Geo T. Hudnet

(Address) 420 N. East Ave

15 Filed Sept 6, 1929 H.A. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3d 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 13th, 1929, to Sept 3d, 1929, that I last saw him alive on Sept 3d, 1929 and that death occurred, on the date stated above, at 5-55 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Usual

(Signed) H. D. Kramer, M. D.

Sept 3d, 1929 (Address) 1929 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 6, 1929
20 UNDERTAKER John Ulrich	ADDRESS 2008 Allegheny

SEP 6 - 1929 HAMILTON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49057 HEALTH DEPARTMENT—CITY OF BALTIMORE 94-001 **E 49057**

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 8-76

CITY OF BALTIMORE: (No. 2113 E North Ave ST.) (WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank L Wolf Sr.

(a) RESIDENCE NO. 2113 E North Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced, HUSBAND of (or) WIFE of Rosa Wolf

6 DATE OF BIRTH (month, day, and year) Sept 9-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	70	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker.

(b) General nature of industry, business, or establishment in which employed (or employer) Mfr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Rosa Wolf

(Address) 2113 E North Ave

15 Filed SEP 6 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4-1929.

17 I HEREBY CERTIFY, That I attended deceased from about 5 days before death to Sept 4, 1929.

that I last saw him alive on Sept 4 1929

and that death occurred, on the date stated above, at 7 45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

one
Hodgkin's disease about six weeks prior to 1929

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 4 days. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? all

(Signed) H. T. Riley, M. D.

Sept 6 1929 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Sept 6, 1929
20 UNDERTAKER	ADDRESS
John Ulrich	2008 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49058
1—PLACE OF DEATH

CERTIFICATE OF DEATH

31 E 49058
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1416 N. Lombard ST. 14-26 WARD)

2—FULL NAME Theodore E. Junghans

(a) RESIDENCE NO. 1416 N. Lombard ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Junghans

6 DATE OF BIRTH (month, day, and year) May 31-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Theo Junghans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Junghans
(Address) 1416 N. Lombard

15 Filed Sept 6 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4-1929

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to Sept 4, 1929
that I last saw h— alive on Sept 3 1929
and that death occurred, on the date stated above, at 10 12 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 8 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) James H [illegible] M. D.

9/5 1929 (Address) 1729 N [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Sept 7, 1929
20 UNDERTAKER John Ulrich	ADDRESS 200 E Orleans St

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks. Thomas J. Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49059

E 49059

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 520 Willow Ave St. 27-48 57 Ward)

2-FULL NAME Thomas J. Saith

(a) RESIDENCE NO. 520 Willow Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Fulligan) Ella T. Saith

6 DATE OF BIRTH (month, day, and year) 6-10-1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Str. Railway Cond
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Scotland

PARENTS

10 NAME OF FATHER Peter Saith

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Catherine McKay

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Scotland

14 Informant Ella T. Saith
(Address) 520 Willow Ave

15 Filed SEP 6 - 1929 19.. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J S Haines, M. D.

9/5-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Grave	9/7/29
20 UNDERTAKER	ADDRESS
Mary M Rudefeld	50 E 32d

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49060

CERTIFICATE OF DEATH

E 49060

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 719 N Dolphin ST., 17-24 (WARD)

2—FULL NAME Jeremiah Hill

(a) RESIDENCE NO. 719 N Dolphin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Hill

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor fruit Stand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nathaniel Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Hill
(Address) 719 N Dolphin

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 / 29

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to Sept 3, 1929

that I last saw him alive on Sept 3, 1929

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Grippe + Rheumatism

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac + Respiratory Paralysis

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Sydney Wallenstein, M. D.

, 19 (Address) 2042 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9/7 19 29
20 UNDERTAKER	ADDRESS
Samuel T Hamilton	578 W Biddle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PB-1525 HAMILTON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49061

74-001

E 49061

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) 554 W. Biddle ST. 17-24 WARD)

2—FULL NAME Emma A. Mathews

(a) RESIDENCE NO. (Usual place of abode) 554 W Biddle ST., WARD

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, Widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE: Years 61; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Maid

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ballo Md

PARENTS

10 NAME OF FATHER James N Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Myra E. Standford

(Address) 554 W Biddle St

15 Filed SEP 6 - 1929, 19 Registrar HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 2nd. 1929 to Sept 3. 1929.

that I last saw h[illegible] alive on Sept. 3rd. 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Usual

(Signed) W. Paul Post M. D.

9-5-1929 (Address) 352 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Leas

DATE OF BURIAL: 9/6 1929

20 UNDERTAKER: Samuel Kennedy

ADDRESS: 578 W. Biddle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49062

CERTIFICATE OF DEATH

31

E 49062

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 S. Robinson ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Hundt.

(a) RESIDENCE NO. 209 S. Robinson ST., 1 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anthony Hundt.

6 DATE OF BIRTH (month, day, and year) Aug 16 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Casmir Nowak.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ida Kosalg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14

Informant Anthony Hundt Husband

(Address) 209 S Robinson St.

Filed SEP 6 1929 19 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 / 29

17

I HEREBY CERTIFY, That I attended deceased from 7-1-29 19 ... to 9-4 ... 1929

that I last saw h[illegible] alive on 8-31- 1929

and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:

Extensive pulmonary Tuberculosis -

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? General clinical + X Ray.

(Signed) S. Drucker M. D.

9-5. 1929 (Address) Medical arts bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery

DATE OF BURIAL: Sept 7 1929

20 UNDERTAKER: Lilly & Zeiler INC.

ADDRESS: [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49063. HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5T E 49063

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland ST. 3-5 WARD)

2-FULL NAME Morris Berger

(a) RESIDENCE NO. 1139 East Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs mos. ds. How long in U. S., if of foreign birth? 25 yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Berger

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Berger

(Address) 1625 N. Smallwood

Filed SEP 6 1929 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5 1929.

17 I HEREBY CERTIFY, That I attended deceased from 9/1 1929 to 9/5 1929

that I last saw him alive on 9/5 1929

and that death occurred, on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Cardiac Failure

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

9/5 1929 (Signed) B. Myerberg, M. D.

(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave. DATE OF BURIAL 9/8 1929

20 UNDERTAKER Jack Levin ADDRESS 1409 E. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 49064

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 W. North Ave. WARD) 3-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Craddock.

(a) RESIDENCE NO. 604 W. North Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph N. Craddock.

6 DATE OF BIRTH (month, day, and year) Mar. 12, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	5	23	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. Hubbard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Drego

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Robert C. Hardin Jr.

(Address) 3205 Mondawmin Ave

15 Filed SEP 6 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to Sept 4, 1929.

that I last saw her alive on Sept 3, 1929,

and that death occurred, on the date stated above, at 2a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

3

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis —

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Tenny —, M. D.

9/4/29 (Address) 604 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Sept 7 1929
UNDERTAKER	ADDRESS
Wm J. Tickner Sons.	North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49065

CERTIFICATE OF DEATH

100-002

REGISTRATION NO. B 49065

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 509 Gorsuch Place St., 17-24 (Ward)

2-FULL NAME Reubon Spencer

(a) RESIDENCE NO. 509 Gorsuch Place St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25-1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto

PARENTS

10 NAME OF FATHER Robt Spencer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Scroggins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mary Scroggins
(Address) 509 Gorsuch Place St

15 Filed 19 Registrar

SEP 6 - 1929 C. HAROLD JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lob Bronchitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pt Causation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Dr Hy Stolon

What test confirmed diagnosis? Dr C G Slade

(Signed) , M. D.

19 (Address) 1430 Ramsay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Sept 8 1929
20 UNDERTAKER John N Joachim	ADDRESS 1027 Hand St

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49066

129 E 49066

REGISTERED NO.

1-PLACE OF DEATH Age M. E. Hem.

City of BALTIMORE: (No. 400 N. Fulton Ave. St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Emma Sanner

(a) RESIDENCE NO. 400 N. Fulton Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) Sept 12, 1849

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	79	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none. D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) md.

PARENTS

10 NAME OF FATHER Geo. Sanner

11 BIRTHPLACE OF FATHER (City or town)

(State or country) St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER Jane Richardson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. J.

14 Informant Miss Etta Cuddy

(Address) 402 N. Fulton Ave.

15 Filed EP 6 - 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Sept 5, 1929.

that I last saw her alive on Sept 4, 1929.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Left Hemiplegia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Geo. E. Shannon, M. D.

(Address) 700 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cem	9/7 1929
20 UNDERTAKER	ADDRESS
Geo J Smith	1537 Hollins

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

E 49067
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St. 4 Ward)

2-FULL NAME Mary Broadschmidt

(a) RESIDENCE NO. 35 S. Ann St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1862

7 AGE: Years 67 | Months 1 | Days 3 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Broadschmidt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Hudgson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Mary Broadschmidt
(Address) 3603 Pelham St

15 Filed SEP 6 1929 19 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1929

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Strangulated Hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas H Brantley M. D.
Sept 4, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lake Redeemer	Sept 7 1929
20 UNDERTAKER	ADDRESS
M. H. E. Duffy & Son	3724 Eastern

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 49068

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Johnson

(a) RESIDENCE NO. 1007 Binney st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Johnson

6 DATE OF BIRTH (month, day, and year) 189/

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lula Stump

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed SEP 6 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1928, to Sept. 5, 1929, that I last saw him alive on Sept. 5, 1929 and that death occurred, on the date stated above, at 6.55 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Glenn M. D.

9-5-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn.	9/7 1929
20 UNDERTAKER Stefaken & Kwiatkowski Inc	ADDRESS 1000 Kenwood Ave

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49069

E 49069

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Md. General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Ida Parker

(a) RESIDENCE NO. Stony Creek, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND (or) WIFE of Late Geo. Parker

6 DATE OF BIRTH (month, day, and year) 9 · 3 · 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	44	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Edward P Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Ida Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Hospital Records

(Address)

15 Filed SEP 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1929

17 I HEREBY CERTIFY, That I attended deceased from 8.25, 1929, to 9.4, 1929

that I last saw h.. alive on 9.4, 1929

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Fine Ventral Hernias

(duration) 3? yrs. mos. ds.

CONTRIBUTORY Broncho Pneumonia 9 days

(Secondary) Peritonitis 4 days (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? Yes Date of 8.26.29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Robert Wells M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Sept 7 1929
20 UNDERTAKER Philip Herring	ADDRESS 306 Orleans

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49070 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-006

E 49070

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2246 Guilford ave ST., 17-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Virginia Hogan

(a) RESIDENCE NO. 2246 Guilford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Dennis F. Hogan

6 DATE OF BIRTH (month, day, and year) Jan. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mahony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Dennis F. Hogan

(Address) 2246 Guilford ave

Filed SEP 6 1929 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 4, 1929, that I last saw h... alive on Sept 4, 1929 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? 0 Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Claud Brunk, M. D.

Sept. 5. 1929 (Address) 4726 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	9/7/1929

20 UNDERTAKER J. J. Moran ADDRESS 3008 E Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49071

CERTIFICATE OF DEATH

161-001

E 49071

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 723 Rice ST. (WARD) 17-26

2—FULL NAME Ashbury Harris

(a) RESIDENCE NO. 723 Rice ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6, 1929

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.: 58 m.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Theodore Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ellen Colbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Augusta Ga

14 Informant

(Address)

15 Filed SEP 6 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1929, to Sept 6, 1929, that I last saw h[illegible] alive on Sept 5, 1929, and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Congenital stenosis (Duration 7 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Sept 6 1929

20 UNDERTAKER: [illegible] Commissioner of Health.

ADDRESS

Please print plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49072

CERTIFICATE OF DEATH

90 E 49072

1-PLACE OF DEATH

City of Baltimore: (No. 1804 Ashburton St. 15-68 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Shelton

(a) RESIDENCE NO. 1804 Ashburton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) March 6 — 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49	5	29 1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Kentucky

PARENTS

10 NAME OF FATHER Mathews C. Shelton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs. P. Keaths
(Address) 1804 Ashburton St

15 Filed Sept 19 1929 No. C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and hour) Sept 5th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. C. Smith, M. D.

Sept 5 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Sept 9 1929
20 UNDERTAKER	**ADDRESS**
Jesse Lyter	1600 W. Pratt ave

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49073

CERTIFICATE OF DEATH

90 E 49073

1-PLACE OF DEATH Pronounced dead at the

City of Baltimore: (No. South Baltimore General Hospital St., 16-42 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Lehman.

(a) RESIDENCE NO. 17 Kenwood Ave Raspeburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, HUSBAND of Mary E. Lehman.

6 DATE OF BIRTH (month, day, and year) May 5, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	3	30 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 0-10
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md,
(State or country)

PARENTS

10 NAME OF FATHER Ansel Lehman.

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ester Hirsch.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Mary E. Lehman. (wife)
(Address) 17 Kenwood Ave, Raspeburg.

15 Filed 9 6 1929, 19 C. HAMPSON JONES, M. D. Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 4, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Light & Montgomery

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

9/6, 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Sept. 7, 1929
20 UNDERTAKER	ADDRESS
Frederick Lovealm Sons	Fullerton

tation should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

162 E 49074

1—PLACE OF DEATH

REGISTERED NO. 25-72

CITY OF BALTIMORE: (No. 2427 Wash. Blvd. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Hoffpel

(a) RESIDENCE NO. 2427 Wash Blvd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Baby -

6 DATE OF BIRTH (month, day, and year): 9/6/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant. [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Herman Hoffpel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Ida L. Tolbert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Father.
(Address) 2427 Wash. Blvd.

15 [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/6/29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1929, to Sept. 6, 1929, that I last saw h[illegible] alive on Sept. 5, 1929 and that death occurred, on the date stated above, at 8.25 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Atelectasis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs.

(Signed) K. B. Boyd, M. D.

19 (Address) 1414 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: Sept 6 1929

20 UNDERTAKER: Poulson

ADDRESS: 2359 Wash Blvd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

SEP 6 - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49075

CERTIFICATE OF DEATH

172-001

E 49075

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 E. Hughes Ave ST., 73-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Dixon Fitchett

(a) RESIDENCE NO. 108 E Hughes ST., Ave WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E. Fitchett

6 DATE OF BIRTH (month, day, and year) Jan 14, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dixon Fitchett

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Mrs Alice E. Fitchett
(Address) 108 E Hughes Ave

15 Filed SEP 6 - 1929 (Signed) H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 27 1929, to Sept 5 1929, that I last saw h— alive on Sept 5 1929, and that death occurred, on the date stated above, at 7.55 a. m.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(duration) yrs. 9 mos. da.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) Geo Turgeon III D, M. D.

9/6/1929 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Sept 7, 1929

20 UNDERTAKER D. Wm Cook ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49076

CERTIFICATE OF DEATH

31

E 49076

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 7-1-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry J Butler

(a) RESIDENCE NO. 836 Woodward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Butler

6 DATE OF BIRTH (month, day, and year) Aug 4th 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	1	1 2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none for months

(b) General nature of industry, business, or establishment in which employed (or employer) Was a policeman

(c) Name of employer for B + O R.R. 061

9 BIRTHPLACE (city or town) New York

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Mary Trubner

(Address) 835 Woodward St

15 Filed 9-6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 3, 1929, to Sept 6, 1929, that I last saw him alive on Sept 5, 1929 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous bronchopneumonia

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac failure

(duration) yrs. 4 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Varney M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. S. National

DATE OF BURIAL 9/9 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

49076 next certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49077

CERTIFICATE OF DEATH

E 49077

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 336 St. Paul ST., 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter de Curzon Poultney

(a) RESIDENCE NO. 336 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 1845

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
83	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Poultney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ellen Bodle Curzon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Richard H Pleasants

(Address) 1011 Munsey Bldg.

15 Filed: 6 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1929, to Sept 4th, 1929, that I last saw h[illegible] alive on Sept 4, 1929, and that death occurred, on the date stated above, at 11.05 m.

The CAUSE OF DEATH* was as follows:

1. Pulmonary Tuberculosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Fractured Hip - due to accidental fall (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H K Pleasants M. D.

9-5, 1929 (Address) 117 W. Hamilton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mt Cem — DATE OF BURIAL: Sept 7 1929

20 UNDERTAKER: Henry A Jenkins Sons — ADDRESS: McCulloh & Oakland Sts

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49078

CERTIFICATE OF DEATH

E 49078

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bellwood Ave east of [illegible] Rd Ward) 26-42 18

2-FULL NAME Jack Wilbur Potter

(a) RESIDENCE NO. 5413 Summerfield Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. - mos. - ds. How long in U. S., if of foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of --------

6 DATE OF BIRTH (month, day, and year) January 14, 1917

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	12	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) McKeesport
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Wilbur E. Potter

11 BIRTHPLACE OF FATHER (city or town) McKeesport
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Virginia I. Roessing

13 BIRTHPLACE OF MOTHER (city or town) McKeesport
(State or country) Pennsylvania

14 Informant Wilbur E. Potter
(Address) 5413 Summerfield Avenue

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 4/29 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning in Quarry Pool, Bellwood Ave east of Belair Road.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

9/6/29 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	9/7 19 29
20 UNDERTAKER Henry W. Mears and Son	ADDRESS 805 N. Calvert

P 7 — 1929

NOTE.—WHITE PEARL INK ONLY TO BE USED. Entries must be made in black ink. This certificate should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 49079 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 49079**

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 671 George ST. 1725 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Reed

(a) RESIDENCE No. 671 George ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of John Reed

6 DATE OF BIRTH (month, day, and year) — — 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Joseph E. Madden (Address) 671 George St

15 Filed Sept 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5. 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/27 1929 to 9/6/29 1929.

that I last saw her alive on 9/6/29 1929.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Intermittent for age

(duration) yrs. 2 mos. 1 ds.

18 Where was disease contracted if not at place of death? ~~No~~

Did an operation precede death? ~~No~~ Date of

Was there an autopsy? ~~No~~

What test confirmed diagnosis? Clinical

(Signed) R. Lee Elder, M. D.

9/6, 1929 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Virginia Martinsburg W. Va.

DATE OF BURIAL Sept. 7 1929

20 UNDERTAKER Miss Katie R. Williams

ADDRESS 3[illegible] Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7 1929

Cor.—10-10-29—A Co.—100 Blks.

E 49080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49080
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital 28-66 St., Ward)

2-FULL NAME Emett Baber

(a) RESIDENCE NO. 328 Frankleintown St. Rd Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucie

6 DATE OF BIRTH (month, day, and year) Nov 22 71

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	9	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Wm Baber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Butler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Wife
(Address)

15 Filed 9-7-1929, 19 C. HAMPSON JONES M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Gun Shot Through Head

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W Brooke M. D.

9/6 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U.S. National Cem	9/7 1929
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	175 Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 4908I

E 4908I

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 398 S. Fulton Ave ST. 14-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Faraci

(a) RESIDENCE NO. 398 S Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0 f

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Cosimo Faraci

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Concettina Camaggio

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Cosimo Faraci

(Address) 398 Fulton.

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

9-1-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5-1929

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to Sept 5-, 1929, that I last saw h[illegible] alive on Sept 5-, 1929 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Hepatitis, acute parenchymatous

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) H. Curtis M. D.

9-6, 1929 (Address) 1300 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	9/9-1929
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	[illegible] Hollins [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49082

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 122-002

E 49082

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 S. Carey ST. 18-29 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta F. Sisley

(a) RESIDENCE NO. 1315 S. Carey ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Julius C. Sisley

6 DATE OF BIRTH (month, day, and year): March 1863

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Julius C. Sisley

(Address) 1315 S. Carey St.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5th 29.

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1928, to Sept 6, 1929, that I last saw h[er] alive on Sept 4, 1929 and that death occurred, on the date stated above, at 6 + 5/12 m.

The CAUSE OF DEATH* was as follows:

Cerrhosis of Liver.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas Smallwood, M. D.

Sept 5, 1929 (Address) 617 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 7, 19 29

20 UNDERTAKER: Wm. J. Flynn — ADDRESS: 617 Lexington St

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 49083

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49083

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Madison Ave St.) (11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Carter

(a) RESIDENCE NO. 1014 Madison Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary D. Carter

6 DATE OF BIRTH (month, day and year) Feb 28-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mercantile Trust Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm H Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mary D Carter (wife) 1014 Madison Ave

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 4/09, 1929, to Sept 5, 1929, that I last saw him alive on Sept 4th, 1929, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

about

(duration) yrs. 5 mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

about (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md Auburn Cemetery

DATE OF BURIAL Sept 8, 1929

20 UNDERTAKER John M. Johnson

ADDRESS 232 Madison Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7-1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49084

CERTIFICATE OF DEATH

23

E 49084

1—PLACE OF DEATH
CITY OF BALTIMORE. No. South Baltimore General Hospital WARD

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily F. Muly

(a) RESIDENCE NO. 4408 Glenarbrook St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 24 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
5	5	11	11 13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Emil C. Muly
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland
12 MAIDEN NAME OF MOTHER: Amelia C. Leonard
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Amelia C. Muly
(Address) 4408 Glenarbrook Ave.

15 Filed ..... 19 ..... THOMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7-29

17 I HEREBY CERTIFY, That I attended deceased from 9-4, 1929, to 9-7, 1929
that I last saw her alive on 9-7, 1929
and that death occurred, on the date stated above, at 8.05 A.m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Encephalitis Lethargica
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Joseph Laukaitis, M. D.
, 19 (Address) 1015 Eutaw Place Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	9/10/29.

20 UNDERTAKER: Frederick Lassahn & Son ADDRESS Fullerton

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

James H. Krozer

E 49085

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001

CERTIFICATE OF DEATH

E 49085

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4027 Belle Ave St. 15-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W Krozer

(a) RESIDENCE NO. 402 Bellevue St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Colnr or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widnwed, nr divorced HUSBAND of (nr) WIFE of Annie Page Krozer

6 DATE OF BIRTH (month, day, and year) July 30 52

7 AGE	Years	Months	Days
	77	1	5

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind nf work Real Estate

(h) General nature of industry, busioess, or establishmeot in which employed (nr employer)

(c) Name nf emplnyer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Dr. Jno R Krozer

11 BIRTHPLACE OF FATHER (City or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Martha Hanebury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Annie P Krozer

(Address) 4027 Belle Ave

15 Filed 19

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5-1929 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 28 19 29 to Sept 5 19 29.

that I last saw h. alive on Sept 5 19 29.

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duratinn) 12 yrs. mos. ds.

18 Where was disease contracted if not at place nf death? Home

Did an nperation precede death? Date of —

Was there an autopsy? No

What test cnnfirmed diagnosis? Blood Picture

(Signed) Geo F Chambers, M. D.

Sept 6. 19 29 (Address) 1524 McCulloh St

*State the Disease Causing Death, nr in deaths frnm Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — Date of Burial Sept 7 1929

20 UNDERTAKER W M Routen — ADDRESS 2235 N Main

SEP 7 - 1929

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49086

CERTIFICATE OF DEATH

E 49086

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. 24-35

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Faust

(a) RESIDENCE NO. 1440 Martin St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Faust.

6 DATE OF BIRTH (month, day, and year) May 18, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.... min.
	21	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Thomas Faust

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER ? Henry ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina.

14 Informant Hospital Records

(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

P 7 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept. 6, 1929, that I last saw h[illegible] alive on Sept. 5, 1929 and that death occurred, on the date stated above, at 12 M. A m.

The CAUSE OF DEATH* was as follows:

Perforated Oesophagus (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bilateral Progressive Pneumothorax (duration) yrs mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ob Spurrier. M.D. M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount N.C.	9-7-1929
20 UNDERTAKER Daniel Carter & Co	ADDRESS 916 N

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49087

228622.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 49087

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 4-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Dean

(a) RESIDENCE NO. 2225 Aisquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/30/29

7 AGE	Years	Months	Days 4	If LESS than 1 day, ... hrs. or ..... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Albert R.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 1 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3-29

17 I HEREBY CERTIFY, That I attended deceased from 8-30, 19 29, to 9-3, 19 29,

that I last saw h alive on 9-3, 19 29

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Asthma neonatorum

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

9/4, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Baltimore Health.

ADDRESS 1929 SEP 1

IMPORTANT: Fill out this certificate of death in plain terms, so that it may be properly classified. Each statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49088

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 49088

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S Popplrton ST. 7-1-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Edw. McCann

(a) RESIDENCE NO. 310 S Popplrton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 21 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1928

7 AGE	Years	Months	Days 20	If LESS than 1 day, hrs. or min.
		1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Junkin McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sophia Quantmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Junkin McCann

(Address) 310 S Popleton St

15 Filed ... 19 ... HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6-29

17

I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to Sept 6, 1929, that I last saw h.. alive on Sept 5, 1929, and that death occurred, on the date stated above, at 12:20 p. m.

The CAUSE OF DEATH* was as follows:

Gastro intestinal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R Morley Strong, M. D.

Sept 7, 1929 (Address) 724 Eutaw Pl. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	9-7 1929

20 UNDERTAKER Armand C Hunt ADDRESS 1400 S Pac St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49089

CERTIFICATE OF DEATH

114 E 49089

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mdlsex Hosp (St.) 9-45 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Kirby

(a) RESIDENCE NO. 1413 Clifton Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jas E Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Isabella Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Hospt Records
(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

P 7 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5/29

17 I HEREBY CERTIFY, That I attended deceased from 9/4/29, 19.., to 9/5/29, 19.., that I last saw h in alive on 9/5/29, 19.., and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH was as follows: Acute Infec Colitis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Influenza ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm H Triplett, M. D.

9/7/29 (Address) Md Gen Hosp

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Sept 7, 19 29

20 UNDERTAKER Robt L Turnbach — ADDRESS 1442 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Latest Statement of Causes important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49090

CERTIFICATE OF DEATH

+ 90

E 49090

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 7-9 Ward)

2-FULL NAME Sanford MacSparran

(a) RESIDENCE NO. 1323 Clifton St., N.W. Wash., D.C. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2s. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	14			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER Mary ---------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Hopkins Records
(Address)

15 FILED SEP 8 1929, 19.. C. HUDSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 7/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Rheumatic Endocarditis
Cardiac Valv. Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature] M. D.

9/7/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington Dale	Sept 8 1929
UNDERTAKER	ADDRESS
Charles H Kehner	Hollins

Spec.—1-10-21—M&T—1500 Bks.

E 49091 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49091

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Swinson

(a) RESIDENCE NO. 130 Fountain ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4, 1934

7 AGE	Years	Months	Days	If LESS than 1 day, / hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant
(Address)

15
Filed SEP 8 1929, 19 C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1934

17

I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1934, to Sept 24, 1934.

that I last saw h 4 alive on Sept 24, 1934,

and that death occurred, on the date stated above, at ~~Sept 4~~ 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mo)

(duration) yrs mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Michael Grossfeld M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carnegie Lab. DATE OF BURIAL 9/6 1934.

20 UNDERTAKER ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49092

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101-001

E 49092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3907 Hayward Ave 27-56 WARD)

2-FULL NAME Elsworth Davis

(a) RESIDENCE. No. 3907 Hayward Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Lottie Davis

6 DATE OF BIRTH (month, day, and year) about 68 years ago

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Farm or road work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER — Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Lottie Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Mrs. Frame (Address) 3907 Hayward

15 Filed SEP 8 - 1929 C. HARRISON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 31 . 1929 . to Sept 6 . 1929 .

that I last saw him alive on " 6 . 1929 .

and that death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

duration 4 8 hours.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General debility

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) H. N. Bebrden, M. D.

, 19 (Address) 3337 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
All Saints Reinterment	Sept 8 1929
20 UNDERTAKER	ADDRESS
A D Marshall	3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Certificate E 49093 CERTIFICATE OF DEATH 146 E 49093

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 27-43 STREET) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Helen Sohn

(a) RESIDENCE NO. 3011 Evergreen Ave Hamilton WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H Sohn

6 DATE OF BIRTH (month, day, and year) Oct 20 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Adam Snyder

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Lena Reigny

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country) Baltimore

14 Informant George H Sohn
(Address) 5501 Easter Ave

15 Filed [illegible], 19 [illegible] HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1929, to September 7, 1929, that I last saw h alive on September 7, 1929, and that death occurred, on the date stated above, at 8 45 a. m. m.

The CAUSE OF DEATH* was as follows:

Puerperal Sepsis

(duration) yrs. 3 wks mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Seman, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forkwood — DATE OF BURIAL 9/10 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 Edmondson Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49094 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 49094

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 7 B 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert F. Windsor

(a) RESIDENCE NO. 1435 Washington Blvd. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unkn yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Windsor

6 DATE OF BIRTH (month, day, and year) Sept 30 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Filmore W. Windsor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1929, to Sept. 7, 1929, that I last saw him alive on Sept. 7, 1929 and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

9-7-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 9/10 1929

20 UNDERTAKER E. Mc Cook

ADDRESS 1115 E. Pratt

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Cone
Jaundice

E 49095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 49095

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4008 Southern St. 41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn B Ewing

(a) RESIDENCE NO. 4008 Southern ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Ewing

6 DATE OF BIRTH (month, day, and year) Aug 13, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Harry Lasco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Clara L Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Williams Ewing

(Address) 4008 Southern Ave

15 Filed SEP 8 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929 to Sept 7, 1929

that I last saw h alive on Sept 7 1929

and that death occurred, on the date stated above, at 7 40 a. m.

The CAUSE OF DEATH* was as follows: Chronic Asthma

Contributory Valvular heart Disease (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Wm D Cone M. D.

9/7, 1929 (Address) Corner Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 1 1929
UNDERTAKER	ADDRESS
Wm Cook	121 N Bond St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49096

154

CERTIFICATE OF DEATH

E 49096

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2 S E ST. WARD)

2—FULL NAME David Goldstein

(a) RESIDENCE NO. 3024 Kelie Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Fabia Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia ?

12 MAIDEN NAME OF MOTHER Rebecca Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia ?

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed SEP 8 - 1929 HAROLD J. JONES, M. Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6-29

17 I HEREBY CERTIFY, That I attended deceased from 6-11, 1929, to 9-6, 1929, that I last saw him alive on 9-6, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Exfoliative Dermatitis (unknown etiology)

(duration) 2 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Anemia, secondary

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. Path. Lab. X-ray

(Signed) Marvin M McLean, M. D.

9-6, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rock Road	9/8 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

Spec.—1-12-23—M&T—500 Bks.

E 49097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 49097

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 1700 WARD)

2-FULL NAME Ferdinand Groshans

(a) RESIDENCE No. 107 E. 33d ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Anna Groshans

6 DATE OF BIRTH (month, day, and year) Oct 23-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jacob Groshans.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Hamburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna Groshans

(Address) 107 E 33rd St

15 Filed SEP 8 1929 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 1929.

17 I HEREBY CERTIFY, That I attended deceased from September 3. 1929. to September 5. 1929.

that I last saw him alive on September 5. 1929

and that death occurred, on the date stated above, at 7 40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Vernon H Norwood M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Sept 9 1929

20 UNDERTAKER John Ulrich

ADDRESS 2008 Odens

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 49098

CERTIFICATE OF DEATH.

Registered No. E 49098

1-PLACE OF DEATH

City of BALTIMORE: (No. 2529 Ridgely St., and 1926 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Bowie

(a) Residence No. 522 N. Carey St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, Col.

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar 16, 1911

7-AGE, 18 yrs. 5 mos. 21 ds. 17.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). /

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Patuxent, Md

PARENTS.

10-NAME OF FATHER. Amos Bowie

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bowie, Md

12-MAIDEN NAME OF MOTHER. Emma Blackstone

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Laurel, Md

13- (Informant) Kate Johnson

(Address) 323 N. Carey St

15- Filed SEP 8 - 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 5, 1929

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1929, to Sept 5, 1929, that I last saw her alive on Sept 4, 1929, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) /

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab.

(Signed) N. Mayo Williams M. D.

Sept 7, 1929 (Address) 1830 Madison Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cemetery	Sept. 8, 1929
20-UNDERTAKER,	ADDRESS
Mrs. Katie R. Williams	322 N. Schroeder St

Exact statement of OCCUPATION is very important. See instructions on back of certificates. In plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49099

CERTIFICATE OF DEATH

40 ✓

E 49099

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3725 Tait ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Bockelage

(a) RESIDENCE NO. 3725 Tait ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Francis) H. Bockelage

6 DATE OF BIRTH (month, day, and year) Feb 5th 1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
76	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Unk.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Gerault.

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country)

14 Informant Catherine Bockelage
(Address) 1008 S. Amity St.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th/29

17 I HEREBY CERTIFY, That I attended deceased from 9am Sept 5th, 1929, to 9 Pm Sept 5th, 1929, that I last saw h[illegible] alive on Sept 5th 5 Pm, 1929 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Val Disease Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation 12 Hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb V Athey M. D.

Sept 7, 1929 (Address) 1008 S Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dark Town Cemetery	Sept 9th 1929
20 UNDERTAKER Lilly & Gilden Inc.	ADDRESS 403 S. Hoya St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Kirk 3126 Harford Rd
74-002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH E 49100 / REGISTERED NO. E 49100

CITY OF BALTIMORE: (No. 4406 Garrison B'lvd ST. 75-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Wallace Adams

(a) RESIDENCE NO. 4406 Garrison B'lvd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alma E. Adams

6 DATE OF BIRTH (month, day, and year) Sept 7th 1869

7 AGE 60 Years	Months 0	Days 0	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Dry Goods

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lawrenceville Ga.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Alma E Adams

(Address) 4406 Garrison Blvd

SEP 8 - 1929 Filed ..... HARRY JONES, M. D. Registrar

By Pelt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7/29.

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to Sept. 7th, 1929, that I last saw him alive on Sept. 7th, 1929 and that death occurred, on the date stated above, at 145 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Robert S. Kirk, M. D.

9/7, 1929 (Address) 3126 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Sept 9th 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49101

CERTIFICATE OF DEATH

E 49101

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 9-46

CITY OF BALTIMORE: (No. ---- ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel F. Shettle

(a) RESIDENCE NO. 953 Gorsuch Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? —yrs. —mos. —ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Agnes Landers.

6 DATE OF BIRTH (month, day, and year) ~~Unknown~~ 10-23-1865

7 AGE	Years	Months	Days	If LESS than 1 day ~~hrs.~~ or ~~min.~~
	63	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House 062

(b) General nature of industry, business, or establishment in which employed (or employer) Watchman

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David Shettle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Stoddert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Records Baltimore City Hospitals
(Address)

15 Filed ---- 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 7, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept 7, 1929, that I last saw h~~im~~ alive on Sept 7, 1929 and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic and acute

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross Exam. Lab.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL 9/10/29.

20 UNDERTAKER George J. Ruth Sons — ADDRESS 1735 Hoffman

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 49102

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital, 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fenie Winstanley

(a) RESIDENCE NO. 1603 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry S. Winstanley

6 DATE OF BIRTH (month, day, and year) 7-15-1877

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	51	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Heinz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Alvater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry S. Winstanley

(Address) 1603 Aisquith St

15 Filed SEP 8 - 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6/29

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1929, to Sept 6, 1929

that I last saw h.. alive on Sept 6, 1929

and that death occurred, on the date stated above, at 9.10 a.m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Lung

(duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) M B Hindry M. D.

19 Address St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	9/9/29
20 UNDERTAKER George J Pulby Sons	ADDRESS 1735 Harford

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49103

CERTIFICATE OF DEATH.

113 E 49103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S Duncan St. ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen B Gorecka

(a) RESIDENCE NO. 310 S Duncan St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Gorecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Eleonora Barach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Castel Del

14 Informant Joseph Gorecki (Address) 310 S Duncan St

15 Filed SEP 8 - 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1929, to Sept. 8, 1929.

that I last saw her alive on Sept. 7, 1929,

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? near Odenton Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lippy, M. D.

19 (Address) 437 S. Catherine St. Ph. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Sept 9 1929

UNDERTAKER John M Weber ADDRESS 401 S Chester St

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49104

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 49104

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Warren Ave. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Pettit.

(a) RESIDENCE NO. 127 Warren Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow

5a If married, widowed, or divorced
(or) WIFE of Robert Pettit.

6 DATE OF BIRTH (month, day, and year) Dec. 15th. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	21 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 1)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert McClean.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margaret Watchman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Elizabeth Miskimon. (sister)
(Address) 127 Warren Ave.

15 Filed SEP 8 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3rd. 1929 to September 5, 1929

that I last saw her alive on September 5, 1929

and that death occurred, on the date stated above, at 1.05 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt, M. D.

9/6, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Sept 9 1929

20 UNDERTAKER John F. Denny ADDRESS 716 Lights

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied.

Spec.—I-10-21—M&T—1500 Blks.

E49105 HEALTH DEPARTMENT—CITY OF BALTIMORE 49105

E 49105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4507 Roland Ave ST. 27-53 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank P. Brady

(a) RESIDENCE No. 4507 Roland Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth C. Brady

6 DATE OF BIRTH (month, day, and year) June 6-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto. Md.
10 NAME OF FATHER Edward Brady
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.
12 MAIDEN NAME OF MOTHER Catherine Bishop
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Elizabeth C. Brady
(Address) 4507 Roland Ave

SEP 8 Filed 1929 19 HAROLD J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 29

17
I HEREBY CERTIFY, That I attended deceased from Sept 6, 1929, to Sept. 7, 1929,
that I last saw him alive on Sept 7th, 1929,
and that death occurred, on the date stated above, at 1- P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy - Cerebral.
-1 day.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no.
What test confirmed diagnosis?

(Signed) Irving Meeks, M. D.
, 19 (Address) 108 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 9/10/29

20 UNDERTAKER Chas. P. Brand & Son — ADDRESS 118 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49106

CERTIFICATE OF DEATH

REGISTERED NO. **E 49106**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ST 17-46 (ARD)

2—FULL NAME Walter Clark Archer,

(a) RESIDENCE NO. ST., WARD Benson. Md,
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/24/15

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Benson
(State or country) Md.

PARENTS

10 NAME OF FATHER Walter H. Archer

11 BIRTHPLACE OF FATHER (city or town) Benson
(State or country) Md.

12 MAIDEN NAME OF MOTHER Loetta Standiford

13 BIRTHPLACE OF MOTHER (city or town) Benson
(State or country) Md.

14 Informant Hospital Records
(Address)

15 Filed Sep 9 1929 19 H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 8, 1929, that I last saw him alive on Sept 8, 1929 and that death occurred, on the date stated above, at 3 35 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica
(diagnosis awaiting confirmation by autopsy findings)

(duration) 0 yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Benson, Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J C Thompson, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mountain ME	Sept 10 1929

20 UNDERTAKER Deer & Forte ADDRESS Belair, Md

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49107.

49106

× 90

E 49107.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. WARD)

2-FULL NAME William Hyatt

(a) RESIDENCE NO. Monrovia, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mildred J. Hyatt.

6 DATE OF BIRTH (month, day, and year) 10-3-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (Truck)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Edgar Hyatt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ella Baker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant (Address) Mrs. Mildred J. Hyatt, R.D. Monrovia, Md.

15 Filed SEP 9 - 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 - 19 29.

17

I HEREBY CERTIFY, That I attended deceased from September 1, 1929, to September 8, 1929, that I last saw him alive on September 8, 1929, and that death occurred, on the date stated above, at 9 00 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

Mitral Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon K Norwood, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montgomery Chapel — DATE OF BURIAL 9/10 - 1929.

20 UNDERTAKER C. M. Maltz. — ADDRESS Westfield Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49108 — CERTIFICATE OF DEATH. — E 49108

1-PLACE OF DEATH St. Agnes Hospital — REGISTERED NO. 25-72

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Taylor

(a) RESIDENCE NO. Hanover, Md R.F.D. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Susanna

6 DATE OF BIRTH (month, day, and year) Oct 2nd 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) /
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) England
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Susanna Taylor
(Address) Hanover Md R.F.D.

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

9-9-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8- 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-28, 1929, to 9-8, 1929, that I last saw her alive on 9-8, 1929, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:
Prostatic & Urinary Calculi 1 yr
Pyelo nephritis - Hydro nephrosis. Mycotic Ureters
(duration) yrs. 6 mos dys.

CONTRIBUTORY (Secondary) Leucaemia and Pneumonia
Congestion (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab - Physical & Autopsy

(Signed) Nicholas P. Bonello, M. D.
, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace Luth Eldridge, Md. — DATE OF BURIAL Sept 11 1929

20 UNDERTAKER John J. Cowan & Son. — ADDRESS 901 Holland St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-103

E 49109
1-PLACE OF DEATH

E 49109
REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hosp. St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsmond T. Armstrong

(a) RESIDENCE NO. 617 S. Pat st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug. 5/25

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Chas. Wm Armstrong

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary A Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Chas. Wm Armstrong

(Address) 617 S. Pat st

15 Filed ..... 19 .....

1563 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to 11th AM on the day stated above.

The CAUSE OF DEATH was as follows: Fract skull L. Parietal & Temporal bones Edge Free from rear platf of Ice (auto) wagon — staggering ride

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupt. ascend. frontal Meningeal artery & intra dural Hemm

(duration) yrs. mos. ds.

(Signed) J. J. Franck M. D.

(Coroner)

9/7 1929 (Address) 2039 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? In 600 Block E. Lafayette

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — Date of Burial 9/9 1929

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans st

(If death should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—2-29-26—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49110

+38

CERTIFICATE OF DEATH

E 49110

1—PLACE OF DEATH Franklin Sq. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 14-27 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William a Clatterbuck

(a) RESIDENCE NO. Arbutus Ave WARD Halethorpe Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. da. 8 How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 2, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 03

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. V. Clatterbuck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susan Armentrout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. M. B. Koontz

(Address) 322 Howard Co. Ave.

15 Filed 9-9 1929 19 G. W. TAYLOR NOSWORTHY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8-29

17 I HEREBY CERTIFY, That I attended deceased from 8-31, 1929, to 9-8, 1929, that I last saw him alive on 9-8, 1929 and that death occurred, on the date stated above, at 1 30 A.m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

Uremia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) General paresis

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & Lab. tests

(Signed) Arthur Patterson M. D.

9/8, 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Reisterstown Md.	9/10/29 19
20 UNDERTAKER Harry V. Witzke, 153 W. Lombard St	ADDRESS

IF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49111

CERTIFICATE OF DEATH

109-002

E 49111

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert T. Phillips

(a) RESIDENCE NO. 668 W. Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle T. Phillips

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Aquilla Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Priscilla ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address) [illegible]

15 Filed SEP 8 1929 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/29

17 I HEREBY CERTIFY, That I attended deceased from 8/29, 1929, to 9/6, 1929, that I last saw him alive on 9/6, 1929, and that death occurred, on the date stated above, at 4 [illegible] P. m.

The CAUSE OF DEATH* was as follows:

Vincent Angina (month)
Vincent infection right lung.
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema right chest
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 9/6/29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) L. C. Lumpkin, M. D.

9/6, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 2 1929
20 UNDERTAKER	ADDRESS
Wm. Geo. H. Holland	1631 Druid Hill Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49112

CERTIFICATE OF DEATH

49 E 49112

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1618 N. Pulaski St. 6-9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bella Zachansky (Schacherenki)

(a) RESIDENCE NO. 1620 E. Balto St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Schachterenko Joseph Zachansky

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 58; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 27

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: David Furman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Kate —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Joseph Zachansky

(Address): 1620 E Balto St

15 Filed ... 19 ... HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8/29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1927, to Aug. 28, 1929, that I last saw h[illegible] alive on Aug. 28, 1929, and that death occurred, on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

chronic cholelithiasis
chronic cholecystitis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma Fundus Ut

Pancreas (duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct-10-1928

Was there an autopsy? yes

What test confirmed diagnosis? Surgical Clinical Lab.

(Signed) R.G. McAllister, M. D.

Sept 8, 1929 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 9/9 1929

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 E Baltimore St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH

REGISTERED NO. E 49113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1620 W. Lexington St. 9-27 WARD)

2—FULL NAME Millie Wise.

(a) RESIDENCE NO. 1620 W. Lexington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Sept 1, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: maryland Howe

(Address) 1624 W Lexington St

15 Filed SEP 9 1929, 19

H. HANSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-6-29.

17 I HEREBY CERTIFY That I attended deceased from 10-12-28, 19, to 9-6-29.

that I last saw her alive on ", 19

and that death occurred, on the date stated above, at 7 a, m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility, heart

(duration) yrs 2 mos. ds.

18 Where was disease contracted if not at place of death? ww

Did an operation precede death? ww Date of

Was there an autopsy? ww

What test confirmed diagnosis?

(Signed) F. M. Caldwell, M. D.

9-7-29 (Address) 1524 Druid Lane,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Sept 9 1929

20 UNDERTAKER: Joseph A Lively

ADDRESS: 409 N Monroe St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49114 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49114

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. 3809 Old York Rd ST., 49-47 (WARD)

2—FULL NAME Elizabeth Verleger

(a) RESIDENCE NO. 3809 Old York Rd ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 3 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Jos. Verleger

6 DATE OF BIRTH (month, day, and year): May 12 1857

7 AGE — Years: 72 | Months: 3 | Days: 25 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Christian Schnapel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: ? Winters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. L. August Verleger

(Address) 540 E. 34th St.

15 Filed 9-1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1929, to Sept. 6, 1929, that I last saw h... alive on Did not see him alive and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

3957 19 (Address) [illegible] Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. DATE OF BURIAL: Sept 9 1929

20 UNDERTAKER: Wm Tuckerman Sons ADDRESS North & Pa

Important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49115

CERTIFICATE OF DEATH.

49 E 49115

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 929 Poplar Grove St (ST.) 16-68 (WARD)

2-FULL NAME Margaret Duval

(a) RESIDENCE No. 929 Poplar Grove St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rufus R. Duvall

6 DATE OF BIRTH (month, day, and year) Dec 29-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Bulack

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Colestock

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Chas F. Schlart

(Address) 929 Poplar Grove

Filed SEP 9 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to Sept 6, 1929, that I last saw h[illegible] alive on Sept 6, 1929, and that death occurred, on the date stated above, at 8-20 A m.

The CAUSE OF DEATH* was as follows:

Epithelioma of Larynx

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. D. Krammer, M. D.

1929 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Baltimore Cem DATE OF BURIAL Sept 9 1929

20 UNDERTAKER Wm J Tickner Sons ADDRESS N. Y. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49116 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 49116**

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 Maude ave Brooklyn ST. 25-75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christina Henrietta Schultz

(a) RESIDENCE NO. 334 Maude ave Brooklyn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 11 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

6a If married, widowed, or divorced HUSBAND of (or WIFE of) William H. Schultz

6 DATE OF BIRTH (month, day, and year) Sept 25th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
54 55	55	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Clemson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Heimel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Irene Smith

(Address) 334 Maude ave

Filed 9-8 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20th, 1929, to Sept 7th 1929.

that I last saw her alive on Sept 6th 1929

and that death occurred, on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and chronic interstitial nephritis

(duration) — yrs. 3 mos. 18 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physicians findings

(Signed) Benj Weibel M. D.

9/9, 1929 (Address) 824 E Hamburg St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Lutheran Dorsett	9/10/1929
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 49117

CERTIFICATE OF DEATH.

E 49117.

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 25 1/2 Calvert ST. 7-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis A. Phelps.

(a) RESIDENCE NO. 912 Burgundy ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	2	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Louis Edward Phelps

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sara Brandt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland.

14 Informant Mother

(Address) 912 Burgundy Street

15 SEP 9 - 1929 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to Sept 7, 1929, that I last saw him alive on Sept 7, 1929, and that death occurred, on the date stated above, at 12:18 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Right)

CONTRIBUTORY (Secondary) None. (duration) yrs. mos. 12 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Wallace Edwards Phelps, M. D.

9/7, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet M. E. Church Cemetery, Anne Arundel County, Md.

DATE OF BURIAL Sept. 9 1929

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49118

E 49118

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 729 S Potomac St., 1-1 Ward)

2-FULL NAME Anna Virginia Zorn.

(a) RESIDENCE NO. 729 S Potomac St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 6 1928

7 AGE: Years 1 | Months 7 | Days 1 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town): Balto.
(State or country)

PARENTS

10 NAME OF FATHER: Andrew Zorn

11 BIRTHPLACE OF FATHER (city or town): Balto.
(State or country)

12 MAIDEN NAME OF MOTHER: Lillian Deggs.

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country)

14 Informant: Andrew Zorn
(Address) 729 S Potomac

Filed SEP 29 - 1929 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastritis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBITORY (Secondary) Convulsions

(duration) ..... yrs. ..... mos. 1/2 hr

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Hospital Records

(Signed) [illegible] M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Sept 29 1929

20 UNDERTAKER: Stephen J Fiszkowski — ADDRESS: 1000 S Kenwood Ave

NOTE.—Items must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49119 — E 49119

CERTIFICATE OF DEATH

1—PLACE OF DEATH South Balto. Gen. Hospital — REGISTERED NO. 27-48

CITY OF BALTIMORE: (No.) ... (ST.) ... (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Florence B Dorsey

(a) RESIDENCE NO. 504 Chatham Ave ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo H Dorsey

6 DATE OF BIRTH (month, day, and year) Oct 26 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) ... (State or country) Md

PARENTS

10 NAME OF FATHER Geo Burgess

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Street

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Md

14 Informant Mrs Sarah Dorsey
(Address) Lutheran Hospital

15 Filed ... 19 ... C. HAMPTON JONES, M. D.
For ... Registrar

9 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7/29

17 I HEREBY CERTIFY, That I attended deceased from 9-3-29, 19..., to 9-7-29, 19..., that I last saw h CV alive on 9-7-29, 19..., and that death occurred, on the date stated above, at 6:55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) ... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of 9-4-29

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Francis W. Tilles, M. D.

, 19 (Address) South Balto. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cem Edison — DATE OF BURIAL Sept 10 1929

20 UNDERTAKER Geo D Mitchell & Son — ADDRESS 1988 Eastern Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

PLACE OF DEATH E 49120

REGISTERED No. E 49120

City of Baltimore: (No. Gilman Apts. St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bolby H. Pector

(a) RESIDENCE NO. 6 Mont. Apt 31 St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Whit-	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ann Waxter

6 DATE OF BIRTH (month, day, and year) Oct 7 1870

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
58	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Commission
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER Howard A Pector

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Mary Leitch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Ann H. Pector
(Address) Gilman Apts Rear

15 Filed Sept 9 1929 C. HAMPSON JONES, M. D. Registrar

Reg.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Cardiac Fil

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. — ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

Sept 9 1929 (Signed) C. Hampson Jones, M. D.

(Address) 142 W Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Sept 9 1929
20 UNDERTAKER John C Mitchell Son	ADDRESS 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 49121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 49 E 49121

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary 6-9 ST. WARD)

2-FULL NAME Mrs. Emma Annie Elizabeth Sealing

(a) RESIDENCE NO. Athelton, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of Walter Sealing

6 DATE OF BIRTH (month, day, and year) March 9 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	46	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

~~10 NAME OF FATHER~~ Walter Wesley Sealing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Walter Sealing

(Address) Finksburg Md

15 Filed C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 2 .1929. to Sept 9 .1929.

that I last saw her alive on Sept 8 .1929.

and that death occurred, on the date stated above, at 1:55 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of Pancreas

Symptomatic (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Obstruction of common bile duct (duration) yrs. 8 mos. 14 ds.

18 Where was disease contracted if not at place of death? Athelton, Md.

Did an operation precede death? Yes Date of 9/4/29

Was there an autopay? No

What test confirmed diagnosis? Operation

(Signed) W. S. Gibson, M. D.

9/9. 1929 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Sept 11, 1929

20 UNDERTAKER Mary P. Stern ADDRESS Ellicott City

TION is very important See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49122

CERTIFICATE OF DEATH

129

REGISTERED NO. E 49122

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Sollers Road-Govans ST., 37-48 WARD)

2—FULL NAME Mary B. Lemke

(a) RESIDENCE NO. 621 Sollers Road-Govans ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Lemke

6 DATE OF BIRTH (month, day, and year) Feb. 14-1872.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Wm J Lemke

(Address) 621 Sollers Road Govans.

15 Filed SEP 10 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7th. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1928, to Sept 7, 1929, that I last saw her alive on Sept 7, 1929 and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Vitlow, M. D.

9/8, 1929 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Sept 10 1929
20 UNDERTAKER	ADDRESS
George W. Zickler	1737 E. Eager st

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49123

CERTIFICATE OF DEATH.

E 49123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST.) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Johnson

(a) RESIDENCE NO. 2051 Guilford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Schmit

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) steward

(c) Name of employer Sun Yat Sun Wilkins Line

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harold Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Betty Rawlins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant hospital records (Address)

15 Filed SEP 9 - 1929 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 6 , 1929 , to Sept 8 , 1929.

that I last saw h alive on Sept 8 , 1929.

and that death occurred, on the date stated above, at 8.40 P m.

The CAUSE OF DEATH* was as follows:

Otitis media chronic suppurative -

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) cerebro spinal Meningitis streptococcus (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical & laboratory

(Signed) Ralph L Porter M. D.

, 19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge, Md.	Sept. 11 1929
20 UNDERTAKER	ADDRESS
George N. Zibler	1737 E Eager St

CAUSE OF DEATH in ... TION is very impr... See instructions on back of certificate. ... classified. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 49124 — CERTIFICATE OF DEATH — **E 49124**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Shakespear St. ST., 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Felix Bienkowski

(a) RESIDENCE NO. 1606 Shakespear St. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Bienkowski

6 DATE OF BIRTH (month, day, and year) 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer Mut. Chemical Co.

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Bienkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant F. Bienkowski
(Address) 1606 Shakrspear St.

15 SEP 9 - 1929 JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7. 1929

17 I HEREBY CERTIFY, That I attended deceased from Septmb 6, 1929, to Septmb 6, 1929.

that I last saw him alive on Septmb 6, 1929

and that death occurred, on the date stated above, at 5. 50 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy.

(duration) yrs. 2 m ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. L. Volentine M. D.

Sept 7, 1929 (Address) 145 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Sept. 10	Sept 10 1929
UNDERTAKER	ADDRESS
Frederick Borzyskii	1930 Eastern ave

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49125

CERTIFICATE OF DEATH.

113

E 49125

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 N. Monroe ST. 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Leonard Thomas

(a) RESIDENCE NO. 100 N. Monroe ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct 23-28

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herman Elmer Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Louise Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs Louise Thomas (Address) 100 N. Monroe St

15 Filed SEP 9 - 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 19 29, to Sept 8, 19 29, that I last saw him alive on Sept 8, 19 29 and that death occurred, on the date stated above, at 7.10 A. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs mos 2 ds

CONTRIBUTORY (Secondary) Acute Bronchitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E Keller Hemmings M. D.

(Address) 2100 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery DATE OF BURIAL Sept 10 1929

20 UNDERTAKER George L. Schmidt ADDRESS 310 Park Ave.

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49126 ~~E 49126~~

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 84

CITY OF BALTIMORE: (No. Emersonian Apts. 2 A. ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Heller

(a) RESIDENCE NO. Emersonian Apts. 2 A. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Castelberg Heller

6 DATE OF BIRTH (month, day, and year) Dec. 28th. 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jewelry

(b) General nature of industry, business, or establishment in which employed (or employer) 038

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Moses Heller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ricky Swartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Gerald Heller

(Address) Ingram Hall Apts.

15 Filed SEP 9 - 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1927, to Sept 8, 1929, that I last saw h-im alive on Sept 8, 1929 and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolus

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 2½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? usual

(Signed) Erwin F. Magee, M. D.

9/9, 1929 (Address) The Esplanade Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	9/10/ 1929
20 UNDERTAKER Klaid Southern	ADDRESS 111 So. W. ave. Royal Oak

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49127

CERTIFICATE OF DEATH

31 V

E 49127

1—PLACE OF DEATH

REGISTERED NO. 1-10

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Bowling

(a) RESIDENCE NO. 14 N. Bradford ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 19 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced, HUSBAND of (or) WIFE of Julia Boone

6 DATE OF BIRTH (month, day, and year) Sept 18, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler-maker

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Bowling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co. Md

12 MAIDEN NAME OF MOTHER Julia Fleming

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Bowling

(Address) 14 N. Bradford

15 Filed 9-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Sept 6, 1929, that I last saw h alive on Sept 6, 1929 and that death occurred, on the date stated above, at 9 00 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1-2 yrs. 8 mos. 0 ds.

CONTRIBUTORY (Secondary) Tuberculous Pneumonia

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? 14 N. Bradford

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis Clinical findings & X-ray

(Signed) Addison Craft Irby, M. D.

9-7, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ballo. Cemetery	Sept 10th 1929
20 UNDERTAKER Lilly & Gilmor Sons	ADDRESS 1038 W. Mpa. St.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49128

CERTIFICATE OF DEATH

E 49128

80

25-72

1-PLACE OF DEATH

City of Baltimore: (No. 1505 Parkesley St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Lorraine Henry

(a) RESIDENCE NO. 1505 Parkesley St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25, 1929

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	7	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Herbert T. Henry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Mildred Conyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Talbot Co. Md

14 Informant Herbert T. Henry
(Address) 1505 Parkesley

15 Filed Sept 9 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Dentition

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke, M. D.

4/4, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 9 1929
20 UNDERTAKER J. B. Stafford	ADDRESS 1005 W. Balto St.

Blue should be carefully supplied. ARE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EP 9 - 1929 Plan.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49129

E 49129

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1742 E. Oliver ST. (WARD) 6-17

REGISTERED NO. 88

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm O. Spamer

(a) RESIDENCE NO. 1742 E. Oliver ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

6 If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE~~ of: Bessie Spamer

6 DATE OF BIRTH (month, day, and year): February 1875

7 AGE — Years: 54 — Months: 7 — Days: 6 — If LESS than day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 109

(r) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Wm Spamer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto, Md

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Informant: Bessie Spamer

(Address): 1742 E. Oliver St

15 Filed SEP 9 - 1929 AMOR[illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7, 1929

17 I HEREBY CERTIFY, That I attended deceased (from August 31, 1929 to Sept 7, 1929 that I last saw h~~is~~alive on Sept 7, 1929 and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Serondary): Acute Myocarditis

(duration) yrs mos. 2 ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Edwin Engvall M. D.

9/8/1929 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: Sept. 9 1929

20 UNDERTAKER: Robt. J. Turner

ADDRESS: 1442 N Broadway

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49130 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2814 Christopher ST. (Ward) 47-43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cashie Webster

(a) RESIDENCE NO. 2814 Christopher ST., WARD Dials Island Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (Husband of (or) Wife of) Julius Webster

6 DATE OF BIRTH (month, day, and year) May 27-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dials Island Md

PARENTS

10 NAME OF FATHER George Windsor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dials Island Md

12 MAIDEN NAME OF MOTHER Cynthia Windsor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dials Island Md

14 Informant (Address) Julius Webster Dials Island

15 Filed SEP 9 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Sept 9, 1929, that I last saw h alive on Sept 9, 1929, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Mitral murmur (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? Dials Island Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr. Lyda Craig M. D.

1929 (Address) 2631 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dials Island Md	Sept 9 1929

20 UNDERTAKER Hughes & Sheridan ADDRESS 1201 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49131 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 49131**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Bernadette Larkins

(a) RESIDENCE NO. 1212 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A. Larkins Jr

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
38 39	11	20	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Richard Gillingham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Mellenie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Wm A. Larkins Jr

(Address) 1212 Hanover St

15 Filed 9 1929 C. HAMPSON JONES, M. D. Registrar

Pat. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/29

17 I HEREBY CERTIFY, That I attended deceased from 5/21, 1929, to 9/6, 1929

that I last saw h alive on 9/6, 1929

and that death occurred, on the date stated above, at 6:5 a m.

The CAUSE OF DEATH* was as follows:

Hypertensive cardio-Vascular disease

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Theo. E. Stacy Jr. M. D.

. 19 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Sept 10 1929
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 Light St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 49132

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49132

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2005 Barclay (St.) 12-19 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick E. Geigan

(a) RESIDENCE NO. 2005 Barclay ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret O'Donnell

6 DATE OF BIRTH (month, day, and year): July 17 1876

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
53	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Galtd Md.

PARENTS

10 NAME OF FATHER: John Geigan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Grennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): John F. Geigan 2005 E. Baltimore

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 7 1929

17

I HEREBY CERTIFY, That deceased from May 31, 1928, to September 7, 1929

that I last saw him alive on Sept. 7, 1929,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF ~~DEATH~~ was as follows:

My Physician, Dr. Carroll

Nephritis and General Dropsy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) My physician

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Geo. L. Wilkinson M. D.

Sept. 7, 1929 (Address) 2248 E. 39th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Sept. 10 1929

20 UNDERTAKER: E. J. Fanning & Son — ADDRESS: Washington & Lafayette

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 49133

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1115 N. Bentalou St. WARD) 16-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gilbert Moog.

(a) RESIDENCE NO. 1115 N. Bentalou St., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 27-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Ignatius Moog.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ga

12 MAIDEN NAME OF MOTHER Elsie Renz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Ignatius Moog.
(Address) 1115 N. Bentalou St

15 Filed ..... 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Sept 7, 1929, that I last saw h was alive on Sept 7, 1929 and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia acute lobar

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Congenital Cardiac disease mental deficiency (duration) life yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lawson Wilkins, M. D.

Sept. 9. 1929 (Address) 1014 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	9-9-1929
20 UNDERTAKER Dana Carter	ADDRESS 916 Eu

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Jones 720 N. Wolfe

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49134 ✓

CERTIFICATE OF DEATH

31 E 49134

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Hamilton Terrace ST., 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Virginia Busold

(a) RESIDENCE NO. 821 Hamilton Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Edward Busold

6 DATE OF BIRTH (month, day, and year) Nov 18 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hse W.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Alexandria Va

(State or country)

PARENTS

10 NAME OF FATHER Wallace A Wallace

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Underwood

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country)

14 Informant Wallace E Wallace

(Address) 3128 S. Washington Pl

15 Filed 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9. 1929

17

I HEREBY CERTIFY, That I attended deceased from July 30, 19 29, to Sept 9, 19 29,

that I last saw h alive on Sept 2, 19 29

and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pneumonia

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Hampson Jones M. D.

9/9, 19 29 (Address) 720 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alexandria Va	9/13 1929
20 UNDERTAKER J. M. Cook	ADDRESS 1217 S Broad St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

139

E 49135

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 702 Hunting Place ST. 28-65 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline J. Hilberg

(a) RESIDENCE NO. 702 Hunting Place ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 24 ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) March 12, 185[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Hilberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Jane E. Reside

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Annie E. Hilberg
(Address) 702 Hunting Place

15 Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 5, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Sep. 5, 1929, that I last saw h[illegible] alive on Sep. 5, 1929 and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Fibroid (uterus)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Perazzo M. D.

Sep. 7. 1929 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery, Govans	9/10 19 29
20 UNDERTAKER Henry W. Mears & Son	ADDRESS 805 W. Calvert

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 113 E 49136

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 707 E Bond ST., 2-4 WARD)

2—FULL NAME Charles Combs

(a) RESIDENCE NO. 707 E Bond ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1928

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Alice Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Amy Combs

(Address) 707 E Bond St

15 Filed 9-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Sept 9, 1929, that I last saw him alive on Sept 8, 1929, and that death occurred, on the date stated above, at 3¼ m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) John H Wade, M. D.

Sept 9 1929 (Address) 118 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	Sept 10 1929
20 UNDERTAKER	ADDRESS
Martin H C Lepper	27 S Gilmor St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

(Rhein) Dr Fenton, Chas Grummond

E 49137

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-007

CERTIFICATE OF DEATH

E 49137

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathaniel Rhein

(a) RESIDENCE NO. 1200 Valley St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary E Rhein

6 DATE OF BIRTH (month, day, and year) Feb 18, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	75	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Rhein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Wahrman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Little Sisters of the Poor
(Address) 1200 Valley St

15 9 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 Sept 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1929, to Sept 8, 1929, that I last saw him alive on Sept 8, 1929, and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

General arterio-sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1200 Valley

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

9-9, 1929 (Address) 1200 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	9/10 1929
20 UNDERTAKER	ADDRESS
J M Cook	1217 E Pratt

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49138

1—PLACE OF DEATH

REGISTERED NO. 92-69

CITY OF BALTIMORE: (No.) 2688 Dulaney ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta D. Hennessy

(a) RESIDENCE NO. 2688 Dulaney ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth 54 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hennessy

6 DATE OF BIRTH (month, day, and year) Nov 15th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) =

(c) Name of employer = 037

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm Tuebke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Tuebke

(Address) 2688 Dulaney St

15 Filed Sept 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to Sept 6, 1929.

that I last saw her alive on Sept 6, 1929

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Klineman, M. D.

Sept 6 1929 (Address) 2057 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 10 1929
20 UNDERTAKER	ADDRESS
H. Kluepfel, 1504 N. Bond St	

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 49139 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49139

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5344 Maple Ave ST. 27-55 WARD)

2-FULL NAME Mary Edith Clift

(a) RESIDENCE NO. 5344 Maple Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day 5 hrs or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Geo Joseph Clift

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Deems.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. E. Clift.
(Address) 5344 Maple Ave.

15 9 - 1929 C. HAMPSON JONES, M. D. Registrar
Date

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/9/ 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/9/29, 19 ..., to 9/9/29, 19 ..., that I last saw h alive on 9/9/29, 19 ..., and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Congenital Incurable Heart Disease

(duration) yrs mos 5 hr

CONTRIBUTORY (Secondary) Same.

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Found

(Signed) Mabel Loyd M. D.

19 (Address) 5913 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sturm's Md

DATE OF BURIAL: Sept 10 1929

20 UNDERTAKER: W M Routson

ADDRESS: 2238 N Avenue

Spec.—1-10-21—M&T—1500 Bks.

E 49140 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49140

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 10 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Wagner

(a) RESIDENCE NO. 2406 St. Paul ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 44 yrs. 0 mos. 0 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frank Wagner Mr. Rose Wagner

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	59	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Morgenthau Germany

PARENTS

10 NAME OF FATHER Friedrich Brecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anne Senk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospt Records

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

P 9 - 1929 Apr

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/5, 1929, to 9/7, 1929, that I last saw her alive on 9/7, 1929, and that death occurred, on the date stated above, at 9 00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) 10 yr (?) mos ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 8/13/29

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease causing Death, or in deaths from Violent Causes, state the Means and Nature of Injury, and (3) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 10/29
20 UNDERTAKER	ADDRESS
Stewart & Mowen Company	108-10 North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49141

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) John Hopkins Hos St., (Ward) 9-11

2-FULL NAME Weldon W. Evans

(a) RESIDENCE NO. 3103 W. Eden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov-12-1909

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or min.
	19	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer) Franklin Printing Co 063
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Rutland Vt

PARENTS

10 NAME OF FATHER Evan W Evans

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Rutland Vt

12 MAIDEN NAME OF MOTHER Bertha Stokes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Boston Mass

14 Informant Evan Evans
(Address) 3103 W. Eden St

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

9 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Fracture Base skull while driving his auto collided with another

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Preston & Lyons (duration) yrs. mos. ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Braun M. D.

9/9, 1929 (Address) 2939 W. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ~~Lutherville Md~~ Sept 11 DATE OF BURIAL 1929

UNDERTAKER W. M. Cook ADDRESS 117 St Paul

Parkwood Cem.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks. Catherine Harding

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49142 118-001 **E 49142**

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital S. 27-44 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Harding

(a) RESIDENCE NO. 5116 Birchwood Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mns. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) H

12 MAIDEN NAME OF MOTHER Eleanor -----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Mrs. Margaret Mayo
(Address) 2804 Bayonne Ave

15 Filed 9 1929 19

C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 7/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia- Strangulated Umbilical Hernia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of Sep 7/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Gatch M. D.

9/9/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cemetery — DATE OF BURIAL Sept. 10, 1929

20 UNDERTAKER E. Leroy Stiffler, Inc. — ADDRESS 125 E. North Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 49143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 **E 49143**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4407 Fernhill Ave., 28-63 Ward

2-FULL NAME Channing Royer Shumway

(a) RESIDENCE NO. 4407 Fernhill Ave., St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Elsie Shumway

6 DATE OF BIRTH (month, day, and year) May 27th 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Buyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Stewart & Co.

9 BIRTHPLACE (city or town)

(State or country) Pottsville, Pa.

PARENTS

10 NAME OF FATHER Channing Shumway

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Ella Whitfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Grace E. Shumway

(Address) 4407 Fernhill Ave.,

15 Filed_____ 19____ C. HAMPSON JONES, M. D. Registrar

EP 16182

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acquired Pict.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 5 ds.

9/29 (Signed) H. C. Slade M. D.
(Coroner)

, 19 (Address) 143 N 13 way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: 9/10 1929

20 UNDERTAKER: J. J. Fickner Sons — ADDRESS: Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

E 49144
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hosp. St. 24-35 Ward)

2-FULL NAME May J. Johnson.

(a) RESIDENCE NO. 1442 Richardson St. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 18 ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 22, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	0	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Fred Brokos.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER May Johnson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bumberland, Md.

14 Informant Fred Brokos. (father)
(Address) 1442 Richardson St.

15 Filed Sept. 9, 1929 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 9, 1929 192

17 I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhoea.
Eclampsia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1442 Richardson St.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto M. Steinhardt, M. D.

9/9, 1929 (Address) 1015 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross 4 & Co	9/10 1929
20 UNDERTAKER	ADDRESS
Chas L. Stevens	1510 E Fort Ave

IMPORTANT—Name should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61-001

E 49145

CERTIFICATE OF DEATH

E 49145

1—PLACE OF DEATH Mercy Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 9-4 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Edward Kelly

(a) RESIDENCE NO. 3707 Greenmount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/4/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Peter Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Magill

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) St. Mary's Co. Md.

14 Informant Peter Kelly
(Address) 3907 Greenmount Ave.

15 Filed SEP 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/29

17 I HEREBY CERTIFY, That I attended deceased from 9-4, 1929, to 9-9-1929, that I last saw him alive on 9-9, 1929 and that death occurred, on the date stated above, at 4.15 p m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

9/9, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Sept. 10, 29.
20 UNDERTAKER	ADDRESS
Rita Needefeld	914 Greenmount Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49146

CERTIFICATE OF DEATH

11-002

E 49146

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1008 Linden Ave (St.) 11-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lloyd

(a) RESIDENCE NO. 1008 Linden Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw. Lloyd

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE — Years: 38 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Miss

PARENTS

10 NAME OF FATHER: Lewis Hurt

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Elizabeth Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Edward Hurt

(Address) 1008 Linden Ave

15 Filed SEP 10 1929 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 5, 1929, to Sept 7, 1929,

that I last saw h alive on Sept 7, 1929,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) — yrs. — mos. 30 ds.

CONTRIBUTORY (Secondary) Cystitis non-suppurative

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. Patterson, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 9/9 1929

20 UNDERTAKER: Samuel Townsley

ADDRESS 578 N Bond

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 ✓ E 49147.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Gorsuch Ave. ST., 9-46a WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Warner Bond

(a) RESIDENCE NO. 704 Gorsuch Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Henry Bond

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph P. Werner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) UnitedStates

12 MAIDEN NAME OF MOTHER Eliza A. Cooke

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. L. Harry Bond
(Address) 704 Gorsuch Ave.

15 Filed SEP 10 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to Sept 9, 1929, that I last saw her alive on Sept. 8, 1929 and that death occurred, on the date stated above, at 12.35 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus
(Primary)
(duration) yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Thomas E. Ward, M. D.

9/9, 1929 (Address) 735 N. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Sept. 11 19 29

20 UNDERTAKER Jacob B Cook — ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49148

REGISTERED NO. E 49148

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp 1400 St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie Brown

(a) RESIDENCE NO. 1428 Druid St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	colored	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Brown

6 DATE OF BIRTH (month, day, and year) Sept 15, 1898

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
30	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Henderson,
(State or country) N. C.

PARENTS

10 NAME OF FATHER Philip Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Polly Wortham

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Samuel Brown
(Address) 626 Laurens St

15 Filed SEP 10 1929, 19.. CLAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Gun Shot Wound (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 5, 29

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. J. Wades, M. D.

(Address) 1426 Berry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Sept 11, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 N Schroeder St.

Not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

18-26 182

REGISTERED NO. E 49149

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Foot of York St. St., 18 Ward)

2-FULL NAME Dennis West.(O)

(a) RESIDENCE NO. 421 N.Carrollton Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -- -------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	48	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Louis West.(O)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Taima -------(O)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Isabelle West.(O)sisterinlaw
(Address) 421 N.Carrollton Ave.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

SEP 10 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 7,1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from P/S Norfolk.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Fernandt, M. D.

9/9, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 10, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 322 N. Schroeder St.

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49150 — **CERTIFICATE OF DEATH** — 117 ✓ — **E 49150**

1—PLACE OF DEATH St Joseph Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST., 27-43 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christian J Bitters

(a) RESIDENCE NO. 3219 Evergreen Ave ST., ____ WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., If foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or WIFE of) Lorella. E. Billera

6 DATE OF BIRTH (month, day, and year) Jan. 27 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	29	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Christian Billera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Minnie Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Lorella E. Billera
(Address) 3219 Evergreen Ave. Hamilton

15 Filed SEP 10 1929 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1929, to Sept 9, 1929

that I last saw him alive on Sept 9, 1929

and that death occurred, on the date stated above, at 7 35 P m.

The CAUSE OF DEATH* was as follows:

General Diffuse
Peritonitis
Ruptured Appendix
(duration) ____ yrs. ____ mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of 9/4/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J H Barranco, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 12 1929
UNDERTAKER	ADDRESS
Henry Wreck Sons Inc	1301 E Eager St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49151 (2 2 8 1 5 1)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49151

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maria Scarbath

(a) RESIDENCE NO. Severn Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William

6 DATE OF BIRTH (month, day, and year): 5-1-85

7 AGE — Years: 44 | Months: 4 | Days: 7 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N. W. 07

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Wm Glieve

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Matilda Bruntz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Sept 8, 1929, that I last saw her alive on Sept 8, 1929 and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of gall bladder with metastases to liver, peri portal lymph nodes, omentum parietal peritoneum, and ovaries. Primary obstruction ..... (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. S. Everett, M. D.

9/8, 1929 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emanuel Cemetery Catonsville Md.

DATE OF BURIAL: Sept. 11 1929

20 UNDERTAKER: Henry Hoech Sons, Inc.

ADDRESS: 601 E Eager

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓

E 49152

CERTIFICATE OF DEATH

REGISTERED NO. **E 49152**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Burgundy ST. 7-1-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E. Archer

(a) RESIDENCE NO. 819 Burgundy ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. 8 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alvena Archer

6 DATE OF BIRTH (month, day, and year) Sept 22. 1871

7 AGE	Years	Months	Days (?)	If LESS than 1 day, hrs. or min.
	57	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Tin Decorating Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md

PARENTS

10 NAME OF FATHER Michael Archer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Susan Dinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Alvena Archer

(Address) 819 Burgundy St.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

P I U 1028

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9-1929.

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to Sept 9th, 1929.

that I last saw him alive on Sept 7th, 1929

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Leonard E Beach, M. D.

, 19 (Address) 2329 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 12 1929.
20 UNDERTAKER	**ADDRESS**
Mr & Mrs. John W Tengle & Son	801 W Fayette

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49153

CERTIFICATE OF DEATH

E 49153

1—PLACE OF DEATH

REGISTERED NO. 94001

CITY OF BALTIMORE: (No. 23-33 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Frampton

(a) RESIDENCE NO. 17 E. Hamburg ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. (mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Frampton

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Circular delivering

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Md.

PARENTS

10 NAME OF FATHER Johnson Frampton

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed P T 0 1929 19 H. [illegible] M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-9-29

17 I HEREBY CERTIFY, That I attended deceased from 1-16, 1929, to 9-9, 1929, that I last saw him alive on 9-9, 1929 and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) yrs. mos. 3 ds. ?

CONTRIBUTORY (Secondary) Hypertension over 8

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ext. P.C.

(Signed) Marvin M. McLean, M. D.

9-9, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem.

DATE OF BURIAL 9/11 1929

20 UNDERTAKER J. Flew McCully

ADDRESS 130 E. Fort

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49154

CERTIFICATE OF DEATH

90

E 49154

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 N. Exeter St ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME FINELLA MARINO

(a) RESIDENCE NO. 305 N. Exeter ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? 30 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	White	Married.

6a If ~~married, widowed, or divorced~~ (or) WIFE of Rocco Marino

6 DATE OF BIRTH (month, day, and year) 4 | 31 | 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or... min.
	58	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chiarino Italy

PARENTS

10 NAME OF FATHER Domenico Barracchini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Rocco Marino

(Address) 305 N. Exeter Street

15 Filed OCT 1 0 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1929, to Sept. 8, 1929, that I last saw h~~e~~r alive on Sept. 8, 1929, and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. V. Lozace, M. D.

19 (Address) 27 E. Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	9/11 1929
20 UNDERTAKER George J. Ruth Jr.	ADDRESS 1730 Harford Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49155 E 49155

CERTIFICATE OF DEATH.

49155

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospitals St., 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Duchacek

(a) RESIDENCE NO. 230 S. Eaton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Henrietta E. Duchacek

6 DATE OF BIRTH (month, day, and year) Feb 17/64

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Schluderberg, Kurdle Co.

9 BIRTHPLACE (city or town)
(State or country): Austria

PARENTS

10 NAME OF FATHER: Frank Duchacek

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Austria

12 MAIDEN NAME OF MOTHER: Rose —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Austria

14 Informant: Henriette E. Duchacek
(Address) 230 S. Eaton St.

Filed OCT 6 1929 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Miliary tuberculosis of lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Ribs

(duration) yrs. mos. 10 ds.

(Signed) James M Kenton M. D.
(Coroner)

9/30 1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 10 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 230 S Eaton St

Former or usual residence "

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leeds Hill Date of Burial Sept 21 29

20 UNDERTAKER: Philip Henry ADDRESS Aulan

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49156 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23

E 49156

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Chorazewicz

(a) RESIDENCE NO. 528 S. Bethel St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 0 mos. 0 ds. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Chorazewicz

6 DATE OF BIRTH (month, day, and year) Dec 6, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland —

PARENTS

10 NAME OF FATHER ? Olander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Chorazewicz

(Address) 528 S Bethel St

15 Filed Oct 1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept 9, 1929, that I last saw h[illegible] alive on Sept 9, 1929 and that death occurred, on the date stated above, at 8 55 a.m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis (Epidemic)

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) None —

(duration) X yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? 528 S. Bethel St —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Interne, M. D.

9-9, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus, Cem.,	Sept. 12-1929
20 UNDERTAKER	ADDRESS
M. J. Sadowski,	2215 Pulaski Ave

Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks. Anna E. Schroth

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49157

CERTIFICATE OF DEATH

47 V

E 49157

REGISTERED NO. 23-32

1-PLACE OF DEATH

City of BALTIMORE: (No. 1738 S. Charles St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Schroth

(a) RESIDENCE NO. 1738 S. Charles St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 5 mos. 19 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White.

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Schroth

6 DATE OF BIRTH (month, day, and year) March, 19, 1877.

7 AGE Years 52, Months 5, Days 19.

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER John F. Jacobs.

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Annie Wilder.

13 BIRTHPLACE OF MOTHER (city or town) Portmouth Va.

(State or country)

14 Informant Annie Jacobs, (Mother)

(Address) 1738 S. Charles St.

15 Filed 10-1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1928, to Sept 8 1929

that I last saw h... alive on Sept 8 1929

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Thos L Campbell M. D.

Sept 10 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. Sept 11 1929 Date of Burial

20 UNDERTAKER E. Howard Evans ADDRESS 38 E Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-29-29 1500 Bks.

E 49158

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49158

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1462 Woodall ST. 24-35 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Paul William Fowble

(a) RESIDENCE NO. 1462 Woodall ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18 1915

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
14	1	23 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Raymond Fowble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll County Md

12 MAIDEN NAME OF MOTHER Sylvia M. Klatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Raymond Fowble
(Address) 1462 Woodall St.

15 Filed Sept 29, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/24/, 1929, to 9/9, 1929, that I last saw h alive on Sept 9/29, 1929, and that death occurred, on the date stated above, at 9.05 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis - Chronic Myocarditis (duration) 6 yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs.

(Signed) James Brown M. D.

, 19 (Address) 705 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westernben	Sept 11 1929
20 UNDERTAKER	ADDRESS
A. Howard Evans	38 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 49159 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49159

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3504 Forest Park Ave Ward) Registered No. 15 5617

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Rosenheim

(a) Residence No. 3504 Forest Park Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Dec. 28, 1860

7-AGE: 68 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Sely Rosenheim

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Henrietta Frank

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14- (Informant): Miss Leah Rosenheim

(Address) 3504 Forest Park Ave.

15- Filed 192 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 9/29

17- I HEREBY CERTIFY, That I attended deceased from 1922 to Sept. 9 1929.

that I last saw her alive on Sept 6 1929.

and that death occurred, on the date stated above, at 12:15 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis, Complicated by Hemiplegia

(Duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Blood Pressure etc

(Signed) Wm B Rider M. D

Sept 9. 1929 (Address) Owings Mills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship DATE OF BURIAL: 9/11/1929

20-UNDERTAKER: Louis Sondheim ADDRESS 1120 W. Mt. Royal Ave

instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 49160 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49160

CERTIFICATE OF DEATH

43

1-PLACE OF DEATH Fenton Memorial Hospital REGISTERED NO. 11324

CITY OF BALTIMORE, (No. 1000 Caton Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Dammann

(a) RESIDENCE NO. 111 West Monument ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Obtainable

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER F. W. Dammann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E McDonald

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md (State or country)

14 Informant Fenton Memorial Hosp (Address) 1000 Caton Ave

15 [illegible] 0 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1929

17

I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to Sept. 9, 1929, that I last saw him alive on Sept. 9, 1929 and that death occurred, on the date stated above, at 8-15 P m.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of Tongue extension into oesophagus. Inoperable

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None (Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Nicholas Lowell, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Sept 11 1929

20 UNDERTAKER Henry W. Mearsdon

ADDRESS 805 N. Calvert St.

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49161

CERTIFICATE OF DEATH

90

E 49161

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Cecil Apt ST. 11-24 WARD)

2—FULL NAME Ella Patterson Poultney

(a) RESIDENCE NO. Eutaw near Dolphin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Married

5a If married, ~~widowed~~, or ~~divorced~~
~~HUSBAND of~~
(or) WIFE of Eugene Poultney

6 DATE OF BIRTH (month, day, and year) Aug 1st 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Perryman Md

PARENTS

10 NAME OF FATHER Geo Goldsboro Cisey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Francis Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant C. L. Clarke

(Address) 37 Warrington Rd

15 Filed OCT 1 0 1929, 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 1929

17

I HEREBY CERTIFY, That I attended deceased from ....., 19.26., to 4 Sept ....., 19 29.

that I last saw h alive on 4 Sept ....., 19 29

and that death occurred, on the date stated above, at 8.20 p m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease
(Mitral Stenosis & Insufficiency)

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) Several yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Horton Streett, M. D.

8/10, 1929 (Address) 11 E Lexington Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Sept 11 1929
20 UNDERTAKER	ADDRESS
Henry J Jenkins & Co	Edmondson Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49162

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49162

CERTIFICATE OF DEATH

× 113

1—PLACE OF DEATH Baltimore Md
Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ~~Lafayette~~ 1111 ST. W-69 (WARD)

2—FULL NAME Charles Young

(a) RESIDENCE NO. 2134 (Usual place of abode) Vine ST., WARD

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	one		nine	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Ada, Oklahoma
(State or country)

PARENTS

10 NAME OF FATHER George A. Young

11 BIRTHPLACE OF FATHER (city or town) Paloshi,
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Agnes Harrell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Father
(Address) 2137 Vine St. Balt. Md

15 Filed 1929 C. HAMPSON JONES, M. D.
Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1929, to Sept 10, 1929, that I last saw h.i.l. alive on Sept. 10, 1929, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. about mos. 24 ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto, Md (home)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Sampson Md, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents Cem	Sept 11 1929
20 UNDERTAKER Geo. W. Settle	ADDRESS 2700 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

Crocker

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49163 90 **E 49163**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3226 Kenyon Ave St. 26-40 (Ward)

2-FULL NAME Raymond U. Crocker

(a) RESIDENCE NO. 3226 Kenyon Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Vera Crocker

6 DATE OF BIRTH (month, day, and year) July 14/1885

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	44	1	26 45	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tool Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Patterson, N.J.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Vera Crocker
(Address) 3226 Kenyon Ave

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

10 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) J. S. H. Potter, M. D.

9/10/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem. Frederick Md.	Sept 11 1929
20 UNDERTAKER	ADDRESS
Wm. E. Blacke	927 N. Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

80 E 49164

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 115 South Carlton St St. 18-24 Ward)

2-FULL NAME Gordon H. Meyers

(a) RESIDENCE NO. 115 South Carlton St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Febry 26, 1929

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles H. Meyers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rena Dahl.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mr Charles H. Meyers
(Address) # 115 S. Carlton St.

15 Filed SEP 11 1929 H. C. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10, 192 9.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dentition -

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brosius M. D.

Sept. 1929 (Address) 3601 3rd St. Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Sept 11, 19 29

20 UNDERTAKER John J. Cowan & Son. — ADDRESS 901 Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49165

CERTIFICATE OF DEATH

129

REGISTERED NO. E 49165

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 S. Bouldin ST. 16-1 (WARD)

2—FULL NAME Americus Helm

(a) RESIDENCE NO. 814 S. Bouldin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Helm

6 DATE OF BIRTH (month, day, and year) Dec 28. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	74	8	10 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 09

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Joseph Helm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Katherine Goetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Joseph Helm (Address) 814 S. Bouldin St.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7-1929

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1929, to Sept 7, 1929, that I last saw h.i.m alive on Sept. 6, 1929 and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Chr. myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Joseph Toulouse M. D.

, 19 (Address) 800 N. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Sept. 11, 1929

20 UNDERTAKER Geo. H. Zeisler — ADDRESS 1737 E. Eager St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49166

CERTIFICATE OF DEATH

REGISTERED NO. **E 49166**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. N 41 Wilkins ST., 20-T WARD)

2—FULL NAME William Tantack

(a) RESIDENCE NO. N 41 Wilkins ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Hannah Tantack~~ 12/13/27

6 DATE OF BIRTH (month, day, and year) Aug 2, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Retired~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Tantack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Trenk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Hannah Tantack

(Address) 639 Wilkins

15 Filed SEP 1 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Sept 9, 1929, that I last saw h. alive on Sept 9, 1929, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. 2 mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Thurnheim, M. D.

(Address) 1617 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 9/11 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Pratt St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49167

CERTIFICATE OF DEATH.

31

E 49167

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3413 Chestnut Ave ST., 13-52 WARD)

2-FULL NAME Lloyd H. Gannon

(a) RESIDENCE NO. 3413 Chestnut Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah Gannon

6 DATE OF BIRTH (month, day, and year) July 17, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 31

(b) General nature of industry, business, or establishment in which employed (or employer) Machinery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Victor Gannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ada Sugg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Beulah Gannon

(Address) 3413 Chestnut Ave

15 Filed SEP 11 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1929

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to Sept 9, 1929, that I last saw him alive on Sept 9, 1929, and that death occurred, on the date stated above, at 2-15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) W. H. Dodson M. D.

(Address) 3538 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Sept 12 19 29

20 UNDERTAKER Chenow & Son

ADDRESS 1115 Hunter

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of occupation is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49168

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Pulaski St. ST., 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick W. Felte

(a) RESIDENCE NO. 319 S. Pulaski St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 11 mos. 25 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Felte(nee Bach)

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Building Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George Felte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna M. Felte.

(Address) 319 S. Pulaski St.

15 Filed 1 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8, 1929

17

I HEREBY CERTIFY, That I attended deceased from August 24, 1929. to September 8 1929.

that I last saw h.. alive on September 8, 1929

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis

(duration) Over 3 yrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Henry C. Ehle M. D.

9-10, 1929 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9/11/29 19

20 UNDERTAKER Harry N Wittle 153 W ADDRESS Lombard

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49169

E 49169

CERTIFICATE OF DEATH

182

REGISTERED NO. 24-35

1-PLACE OF DEATH

City of Baltimore: (No. Foot of Cooksie St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James M. Brethauer Jr.

(a) RESIDENCE NO. 1430 Haubert St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) July 12th. 1921

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	8	0	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James M. Brethauer Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Gertrude Jones.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant James Brethauer Sr. (father)
(Address) 1430 Haubert St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 9, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a sand bar while at play.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Inquiry.

(Signed) Otto M. Leonhardt, M. D.

9/10 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	9/12 1929
20 UNDERTAKER	ADDRESS
Charles L. Evans	1300 E. Lanvale

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49170

CERTIFICATE OF DEATH

+ 57

E 49170

1—PLACE OF DEATH St Joseph Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 9-17 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mathilda Gorub (GORUB)

(a) RESIDENCE NO. Franklin & Taylor Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Gorub

6 DATE OF BIRTH (month, day, and year) Feb 27th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Conrad Gorub husband

(Address) Franklin & Taylor ave. Estex

15 Filed OCT 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Sept 10, 1929

that I last saw h.. alive on Sept 10, 1929

and that death occurred, on the date stated above, at 12.15 Am.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Streptococcemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of 9/9/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S H Barranco, M. D.

, 19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Sept 13th 1929
20 UNDERTAKER Lilly & Zeiler Inc	ADDRESS 403 S Wolfe St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49171 HEALTH DEPARTMENT—CITY OF BALTIMORE 45

CERTIFICATE OF DEATH

E 49171

1—PLACE OF DEATH

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2207 Brookfield Ave (ST.) (WARD)

2—FULL NAME Sarah Lipman

(a) RESIDENCE NO. 2207 Brookfield Ave ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Hyman Lipman

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 55 — Months: — — Days: — — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Israel Grodman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hyman Lipman

(Address): 2207 Brookfield Ave

15 Filed P 11 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/10/29

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2 19 29 to Sept. 10 19 29 that I last saw h[illegible] alive on Sept. 9 19 29 and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes. Date of Jan. 12 29.

Was there an autopsy? no.

What test confirmed diagnosis? Physical & Microscopic

(Signed) Walter C Baker M. D.

19 (Address) 719 Med Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem — DATE OF BURIAL: 9/11 19 29

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 Eutaw Place

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49172

24 E 49172

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bald City Hosp (or) 16-22 Ward)

2-FULL NAME James Lee Brooks

(a) RESIDENCE NO. 1406 Riggs Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Sgl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	15	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Henry Brooks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Nobia Curtis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Nobia Curtis
(Address)

15 Filed ....., 19.... [illegible] Registrar

SEP 1 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or Inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1407 Riggs Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Microscopic

(Signed) James W Denton M. D.

9 10 1929 (Address) 7002 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9-10 1929
20 UNDERTAKER	ADDRESS
Leon Eaton	Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 18-29 Ward

2-FULL NAME John Green

(a) RESIDENCE NO. 904 Boyd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lucy Green

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 240
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Lucy Green
(Address) 904 Boyd St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorhage due to revolver wound of abdomen
Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 904 Boyd St

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

9/9. 1929. Address 2739 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	9-11 1929
20 UNDERTAKER Daniel Easter	ADDRESS 816 Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49174

49 E 49174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2223 (Street) Pulaski (ST.) 25-72 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Schultheis

(a) RESIDENCE No. 2223 Pulaski ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Maggie Schultheis

6 DATE OF BIRTH (month, day, and year) Sept 6 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	m	2 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 0.15

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Casualty Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Schultheis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER [illegible] Sept 15, 19[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Maggie Schultheis (Address) 2206 Pulaski

15 Filed SEP 11 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 19 29

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1929, to Sept 9, 1929, that I last saw him alive on Sept 9, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) General Cancerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) H. B. Jetton M. D.

(Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	9/12 1929
UNDERTAKER Edward Foulon	ADDRESS 2309 Druid Hill Ave

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49175
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

38 E 49175
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 902 N. Dallas st ST. 7-13 WARD)

2-FULL NAME Mary Hyland

(a) RESIDENCE NO. 902 N. Dallas St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widowed.

5a If married, widowed, or divorced HUSBAND of or) WIFE of Alonzo Hyland

6 DATE OF BIRTH (month, day, and year) [illegible] 1889

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Slacum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Buchanan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bessie Comegys
(Address) 902 N Dallas St

15 Filed ..... 19 ..... C. HAMILTON ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1927

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1927, to Sept 8, 1927, that I last saw her alive on Sept 8, 1927, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) Calvin B. LeCompte M. D.

, 19 (Address) 814 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Calvary DATE OF BURIAL Sept 11, 1927

20 UNDERTAKER Mrs R. G. Allen ADDRESS 1425 Eastern Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49176
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 E 49176

CITY OF BALTIMORE: (No. 1823 E. Eager ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Thomas J. Simms

(a) RESIDENCE No. 1823 E. Eager ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Simms

6 DATE OF BIRTH (month, day, and year) Feb. 16 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 054

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER J Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Howard Simms

(Address) 1823 E Eager St

15 Filed SEP 11 1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1929

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1929, to Sept 10, 1929, that I last saw h in alive on Sept 10, 1929, and that death occurred, on the date stated above, at 4 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Ayd M. D.

19 (Address) 1437 S Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Sept 12 1929
20 UNDERTAKER Geo M. Smith & Son	ADDRESS 811 N Wolfe

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ✓ E 49177

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Bosse

(a) RESIDENCE NO. 634 N. Belnord ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Bosse

6 DATE OF BIRTH (month, day, and year) April 3-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. Bosse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Heckenatme

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wonner Schutte

(Address) 2426 E. Monument St

15 Filed SEP 1 1929 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/29

17 I HEREBY CERTIFY, That I attended deceased from 9/3/29, 19..., to 9/9/29, 19...

that I last saw him alive on 9/9/29, 19...

and that death occurred, on the date stated above, at 12:30 P.m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

CONTRIBUTORY (Secondary) Ruptured bloodvessel and hematoma leg (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 35 ds. Home

Did an operation precede death? Yes Date of 9/9/29

Was there an autopsy? No operation

What test confirmed diagnosis

(Signed) A. McElwaine M. D.

Address 1. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Sept 2 29

20 UNDERTAKER Geo M. Frick & Son — ADDRESS 811 N Wolfe

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49178

CERTIFICATE OF DEATH

100-002

E 49178

1-PLACE OF DEATH

City of Baltimore: (No. 1711 Lormand St., 15-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Hall

(a) RESIDENCE NO. 1711 Lormen St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 22 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 19, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER H Hall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mudd Hudgins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mudd Hall
(Address) 1711 Lormand St

15 Filed SEP 11 1929, 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Coryza Bronchitis

(duration) — yrs. — mos. 2 ds.
CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. — ds.
18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What tests confirmed diagnosis? History
(Signed) H. G. Slade M. D.
, 19 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	9-11 1929
20 UNDERTAKER	ADDRESS
Joseph A Sibley	1029 N Mont

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49179 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 49179

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gilbert M. Underwood

(a) RESIDENCE NO. 2012 W. Pratt st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER A. J. Underwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER ~~Sara C. Byrne~~ SUSAN C PERINE

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1928, to Sept. 7, 1929,

that I last saw him alive on Sept. 7, 1929

and that death occurred, on the date stated above, at 6.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Clinical

What test confirmed diagnosis? No

(Signed) Jos. Arnold Jr., M. D.

9-8, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Sept 11 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49180

1—PLACE OF DEATH

CERTIFICATE OF DEATH

31 ✓

E 49180

REGISTERED NO.

CITY OF BALTIMORE: (No. 510 S. Ellwood Ave. ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ANNA M. ECKERT

(a) RESIDENCE NO. 510 S. Ellwood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frederick J. Eckert Jr.

6 DATE OF BIRTH (month, day, and year) March 12, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER August Kathmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. F. J. Eckert Jr. (Husband)

(Address) 510 S. Ellwood Ave.

15 Filed ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1924. to July 10, 1929. that I last saw h in alive on July 10, 1929 and that death occurred, on the date stated above, at 12.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Sept. 13, 1929

20 UNDERTAKER Henry Sander & Sons Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

Important. See instructions on back of certificate.

Spec—12-23-2—E.B.&S.—400 Eks.

E 49181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 001 E 49181

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1443 Hall St 41-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Carnish

(a) Residence No. 1443 Hall St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Sngle

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Sept 8, 1929

7-AGE. yrs. mos. ds. If LESS than 1 day, 2½ hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) bb

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Geo E Jenkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Charles Co, Md

12-MAIDEN NAME OF MOTHER: Rebecca Carnish

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md

14- (Informant) Horace Strickland

(Address)

15- Filed Sep 11 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 8, 1929

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 1929 to Sept 8 1929

that I last saw h/M alive on Sept 8 1929

and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Prematurity - (26 wks)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paternal Cause

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Paternal Cause.

(Signed) Frank A Reading Jr M. D.

1929 (Address) Forest Park P.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL. 19

20-UNDERTAKER. A Bladder Bur.

ADDRESS

SEP 11 1929

instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49182

CERTIFICATE OF DEATH

31

E 49182

1—PLACE OF DEATH Baltimore City Hospitals (T-9) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Talbot

(a) RESIDENCE NO. 411 N. Bethel st. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jonas Talbot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Sept. 7, 1929, that I last saw him alive on Sept. 7, 1929, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

9-8-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

(Commissioner Health) SEP 11 1929

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49183

1—PLACE OF DEATH

CERTIFICATE OF DEATH

9VE 49183

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balt. City Hospital ST. 18-29 WARD)

2—FULL NAME John Barrett

(a) RESIDENCE NO. 108 Mt. Elm alley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5-9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Odd Jobs.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Barrett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hospital Record
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7/29

17 I HEREBY CERTIFY, That I attended deceased from 9/26, 1928 to 9/7, 1929.

that I last saw him alive on 9/7, 1929

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Old fistulous tract of upper abdominal wall

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary thrombosis

(duration) yrs. mos. 1 hr.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Pumphrey, M. D.

9/7, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

SEP 11 1929

IMPORTANT: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49184

1-PLACE OF DEATH

City of Baltimore: (No. 909 Books Lane) (St.) (Ward) 17

2-FULL NAME Charles L Rediker

(a) RESIDENCE NO. 909 Books. Lane St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

E 49184

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Margaret Rediker

6 DATE OF BIRTH (month, day, and year) Dec 6, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	9	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Schaffer & Co 009

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER George E Rediker

11 BIRTHPLACE OF FATHER (city or town) Balt Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Geo L Rediker
(Address) 909 Cold Lane

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.
Inquest, autopsy or inquiry

The CAUSE OF DEATH* was as follows: Suicide
Gun Shot Wound Head
Perforated

(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. — ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Eye Exam

(Signed) H C Hampson M. D.

19 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	9/12 19 24
20 UNDERTAKER J M Cook	ADDRESS 1218 Bond St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1929 C. HAMPSON JONES

Spec.—1-10-21—M&T—1500 Bks.

E 49185 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 49185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 S. Bond St. ST. 34 WARD)

2-FULL NAME Martin Szpniewski

(a) RESIDENCE NO. 710 S. Bond St. ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Labor 040

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Szpniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Lottie Bujewska
(Address) 222 S Linwood Ave.

15 Filed SEP 11 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 29, to Sept 10, 19 29
that I last saw h alive on Sept 10, 19 29.
and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis R. Sauer M. D.
(Address) 1 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Sept 13 DATE OF BURIAL 1929

20 UNDERTAKER John M Weber ADDRESS 401 N Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49186

CERTIFICATE OF DEATH.

100 E 49186

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4510 St George Ave (ST.) 27-48 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Chambers

(a) RESIDENCE. NO. 4510 St George Ave ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs mos ds. How long in U. S., if of foreign birth? 30 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura

6 DATE OF BIRTH (month, day, and year) Apr 9 - 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Cuba

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Laura Chambers

(Address) 4510 St George Ave

15 Filed SEP 12 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1929

17

I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to Sept 10, 1929, that I last saw h~~im~~ alive on Sept 10 - 1929, and that death occurred, on the date stated above, at 5-26 P m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis (Surg)

(duration) X yrs. 3 mos. X ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) X yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H H Benson M.D.

11. 1929 (Address) 6010 York Road

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt Auburn Sept 12 1929

20 UNDERTAKER — ADDRESS

Franklin W Seitz 709 W 33 St

TION is very important. See instructions on back of certificates.

that it may be properly classified. Exact statement of OCCUPA-

Cor.—10-10-29—A Co.—100 Bks.

E 49187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49187

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 272 S Highland St., 16-2 Ward)

2-FULL NAME Simon Martin

(a) RESIDENCE NO. 272 S Highland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
about 70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Worker
(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER unknown Martin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Ellen Pritchett
(Address) 272 S Highland Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 272 S. Highland

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

9-11-1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lawn Cem

DATE OF BURIAL Sept 12 1929

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 12 1929

C. HAMILTON JONES

Spec.—1-10-21—M&T—1500 Bks.

Hackman.

E 49188 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 49188

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hospital for the Women of Maryland

CITY OF BALTIMORE: (No.) Lafayette and John ST. 14-20 (WARD)

2-FULL NAME Gudie Christina Hackman

(a) RESIDENCE NO. Selby Maryland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 mos. 21 ds. How long in U. S., if of foreign birth? (If non-resident give city or town and State) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Leonard Hackman

6 DATE OF BIRTH (month, day, and year) January 21, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Charles Conrad Seibel

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mathilda Palm

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) Maryland

14 Informant John Leonard Hackman (Address) Selby Maryland

15 Filed , 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1929

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1929, to September 12 1929, that I last saw h[illegible] alive on September 12, 1929, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of pan- creas Metastasis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of {Aug. 6, 1929 / Sept 10, 1929}

Was there an autopsy? No

What test confirmed diagnosis? at operation

(Signed) Earle P. Clemson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Sept 14, 1929

20 UNDERTAKER John Merrick ADDRESS 908 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49189

CERTIFICATE OF DEATH

113

E 49189

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 E. Barney St ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vera M. Feeley

(a) RESIDENCE NO. 112 E. Barney St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 27 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael J. Feeley

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Christina Kelm

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14

Informant Mr. M J Feeley

(Address) 112 E. Barney St

15

Filed SEP 12 1929 HANSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11-29

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Sept 11, 1929,

that I last saw h[illegible] alive on Sept 11, 1929

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) J. H. Campbell M. D.

Sept 11, 1929 (Address) 1669 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL 9/13 1929

20 UNDERTAKER J. Fenwick McCully

ADDRESS 130 E Fort

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49190

CERTIFICATE OF DEATH.

161-001

E 49190

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 S. Exeter ST., 3-5 WARD)

2-FULL NAME Infant Bastianelli

(a) RESIDENCE NO. 248 S. Exeter ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 minutes ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 11/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or 2 min.
-				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Alexander Bastianelli

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Julia Annarelli

13 BIRTHPLACE OF MOTHER (city or town) London
(State or country) England

14 Informant Julia Bastianelli
(Address) .....

15 Filed SEP 12 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept 11, 1929, that I last saw him alive on Sept 11, 1929 and that death occurred, on the date stated above, at 6.27 A m

The CAUSE OF DEATH* was as follows:

Premature delivery

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) other twin lost Friendless past two weeks

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Mary L Kilpatrick M. D.

Sept 11 1929 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Rohrer Slate Board — DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

SEP 12 1929

THION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

227998 E 49191 CERTIFICATE OF DEATH 52 E 49191

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 16-37 WARD)

2—FULL NAME Evangeline Paraskevas

(a) RESIDENCE NO. 410 S Oldham ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/4/28

7 AGE	Years 1	Months 2 / 13	Days 7	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md. Baltimore

PARENTS

10 NAME OF FATHER Miltradis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Georgia Nitona

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11-29

17 I HEREBY CERTIFY, That I attended deceased from 8-9-, 1929, to 9-11-, 1929,

that I last saw her alive on 9-11-, 1929

and that death occurred, on the date stated above, at 8:15 a m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Multiple abscesses

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy. Blood cultures

(Signed) Lt Campbell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	9/12 1929
20 UNDERTAKER George J. Pulla	ADDRESS 1733 Harford

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 49192

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4422 Powell Ave ST., 26-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Otto Erhardt

(a) RESIDENCE NO. 4422 Powell Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie F. Grothues

6 DATE OF BIRTH (month, day, and year) 5/19/1903

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Govt.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Fred C. Erhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary A. McGarvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Marie Erhardt

(Address) 4422 Powell Ave

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11/29

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Sept 11, 1929

that I last saw him alive on Sept 10, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary abscess -
Pulmonary tuberculosis of throat -

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H S Gray — M. D.

9/11/29 (Address) 609 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 9/13/29

20 UNDERTAKER Geo. J. Pulk

ADDRESS 1735 Hanover

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49193

REGISTERED NO. E 49193

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH East Fell St

City of Baltimore: (No. 127 S. Dallas St., 3-4 Ward)

2-FULL NAME Thomas Disharoon

(a) RESIDENCE NO. 127 S Dallas St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Sing'l

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year): January 4/13

7 AGE — Years: 15 | Months: 8 | Days: 7 8 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School b
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country) Anna Arundel Co

PARENTS

10 NAME OF FATHER Elias Disharoon

11 BIRTHPLACE OF FATHER (city or town):
(State or country) A A Co Md

12 MAIDEN NAME OF MOTHER Louisa Disharoon

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) A A Co Md

14 Informant E E Johnson
(Address) 1400 Eastern ave

15 Filed ....., 19.. C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Fort Fell St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding of Water

(Signed) James M Fenton M. D.

11. 1929 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashbury Cem. — DATE OF BURIAL: 9/13/29

20 UNDERTAKER: Geo J. Ruth — ADDRESS: 1735 Hanford

IT IS IMPORTANT that this Certificate of Death be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 49194 DEATH

REGISTERED NO. E 49194

CITY OF BALTIMORE: (No. 1302 John ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Lucas

(a) RESIDENCE NO. 1302 John ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

If married, widowed, or divorced: (a) HUSBAND of (or) WIFE of: George Wm. Lucas

6 DATE OF BIRTH (month, day, and year): June 2, 1849

7 AGE: Years 80 Months 3 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Littleton S. Read

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mr. Wm. B. Lucas
(Address): Ruxton, Md.

15 Filed 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 9th, 1929, to Sept 11th, 1929, that I last saw h[illegible] alive on Sept 10th, 1929 and that death occurred, on the date stated above, at 6.50 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. S. Tyltaut, M. D.

9, 11, 1929 (Address) 211 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charles Town, W. Va.	Sept 13, 1929
20 UNDERTAKER	ADDRESS
John C. Mitchell & Sons	1900 Eutaw Place

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49195

CERTIFICATE OF DEATH.

129 E 49195

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1926 Oak Street (Ward) 18

2-FULL NAME Emma Guy Hines

(a) RESIDENCE NO. 1926 Oak Street WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas M. Hines

6 DATE OF BIRTH (month, day, and year) Oct 8 67

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
61	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos Slemmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Jane Guy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thos M. Hines (Address) 1926 Oak Street

15 Filed Sept 12 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1929, to Sept 10, 1929, that I last saw h alive on Sept 10 1929, and that death occurred, on the date stated above, at 5-15 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - Uraemic Hepatitis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonic Tuberculosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H S Gray M. D.

9/11/29 (Address) 622 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Sept 12 1929

20 UNDERTAKER W M Rowton

ADDRESS 22 S W Smith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49196 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

E 49196

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 27-35 WARD)

2-FULL NAME Samuel Weiss

(a) RESIDENCE NO. 6106 First Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Weiss

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Dave Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wolkon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Morris Epstein

(Address) 210 E Baltimore St

15 Filed SEP 12 1929, 19 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 1929

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to Sept. 11, 1929, that I last saw h[illegible] alive on Sept. 11, 1929, and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary neoplasm.
Pericardial effusion

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Thoracentesis; autopsy

(Signed) B. Cohe M. D.

9/11, 1929 Address Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Cem DATE OF BURIAL 9/12 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Margaret J Hammen.

49197

HEALTH DEPARTMENT—CITY OF BALTIMORE

Mercy Hospital

CERTIFICATE OF DEATH

161-001

E 49197

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST. 27-43 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Hammen

(a) RESIDENCE NO. 3400 E. White Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mercy Hosp.
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Lewis Hammen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margt. Helwig

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mercy Hospital
(Address) Records

15 Filed SEP 14 1929 19 HERMAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11/29.

17 I HEREBY CERTIFY, That I attended deceased from 9/3/29, 19..., to 9/11/29, 19...,
that I last saw h er alive on 9/11/29, 19...
and that death occurred, on the date stated above, at 11:35 p.m. m.
The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Asphyxia Livida

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Turner, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 13 1929

20 UNDERTAKER J. W. E. Lloyd & Son ADDRESS 37 Lexington

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49198

CERTIFICATE OF DEATH

9°

E 49198

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 13 S. Calhoun St., 1929 Ward)

2-FULL NAME Amelia A. Bowers

(a) RESIDENCE NO. 135 Calhoun St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	75	-	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Bowers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Stumpf

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Chas. E. Bowers
(Address) Balto Md

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.
The CAUSE OF DEATH was as follows:
Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Brooke M. D.

Sept. 12. 1929 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	9/13 1929
20 UNDERTAKER	ADDRESS
George J. Smith & Son	32 Holliday St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 12 1929

Spec.—1-10-21—M&T—1500 Blks.

E 49199 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49199
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 E. North Ave St.) (WARD) 12-19

2-FULL NAME Walter A. Spice

(a) RESIDENCE No. 266 Valentine Ave (St.) New York City (WARD)
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Edith Spice

6 DATE OF BIRTH (month, day, and year): Jan 17-1879

7 AGE — Years: 50 — Months: 7 — Days: 24 — If LESS than 1 day, hrs. or min.: 23

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): 009
(c) Name of employer: P. R. R.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS
10 NAME OF FATHER: Augustus Spice
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto
12 MAIDEN NAME OF MOTHER: Mary Shaney
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant (Address): Edith Spice wife 266 Valentine Ave New York city

15 Filed ... 19 ... H. LAMSON MOALES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 10= 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 . 1929 to Sept 10 . 1929
that I last saw h[illegible]ive on Sept 10 . 1929
and that death occurred, on the date stated above, at 10 45 Am.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Heart failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dr Reginald F. Jones M.D.
. 19 (Address) 4142 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 10/13 1929
20 UNDERTAKER: Chas. P. Graves Son — ADDRESS: 1[illegible] N. Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49200

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49200

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hosp. + 101

CITY OF BALTIMORE: (No. Balto. Md. ST. 11-21 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack H. Sherman M.D.

(a) RESIDENCE NO. Manchester, Md ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician.

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Jesse Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record.
(Address)

15 Filed SEP 12 1929 19 ..... Registrar

F. HAMMONDS, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1929. to Sept 12, 1929.
that I last saw him alive on Sept 12, 1929.
and that death occurred, on the date stated above, at 6 45 Am.
The CAUSE OF DEATH* was as follows:

Adenoma Prostate Gland.

(duration) 30 yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 10, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Reifschneider, M. D.

9/12, 1929 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Md	Sept 14 1929
20 UNDERTAKER	ADDRESS
Jacob Winkelmans Sons	Manchester Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 49201

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Eye Ear Throat Hosp. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Jackson Cunningham

(a) RESIDENCE NO. Balto Eye Ear Throat Hospital ST., WARD Pike W. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., If foreign birth? 61 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lavina Cunningham

6 DATE OF BIRTH (month, day, and year): About August 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pumper in an Oil Field

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Hennegan & Hanlon Co.

9 BIRTHPLACE (city or town): Pike
(State or country): West Virginia

PARENTS

10 NAME OF FATHER: ? ? Cunningham

11 BIRTHPLACE OF FATHER (city or town): Pike
(State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Louise Hammond

13 BIRTHPLACE OF MOTHER (city or town): Pike
(State or country): W. Va.

14 Informant: Wm. L. C. Cunningham (Son)
(Address): Parkersburg W. Va.

15 Filed SEP 13 1929 19 C. HAMMOND JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Friday Sept 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to September, 1929, that I last saw him alive on Thursday Sept 12 6A.M. 1929 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis - following operation for Carcinoma of Sphenoid sinus (Pt)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 11, 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. L. Breitstein, M. D.

19 (Address) 1211 Eutaw Place Apt 95

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pike - W. Va. DATE OF BURIAL: Sept 13, 1929

20 UNDERTAKER: Stewart & Company ADDRESS: Balto Md.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49202

188-103

E 49202

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 411 S. Chester St 9-64 St., Ward)

2-FULL NAME Margaret C. Leek

(a) RESIDENCE NO. 343 Stinson St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of dead

6 DATE OF BIRTH (month, day, and year) Oct- 15-1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	73	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Doole

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) not known

14 Informant Thomas H. Leek
(Address) 313 Franklin Road

15 Filed ..... 19.. Registrar

SEP 12 1929 C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

Myocarditis
Struck & knocked down by auto
while leaving curb—

CONTRIBUTORY (Secondary) Hypostatic Pneu (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Frankletown Rd & Hafer Rds City
(duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Observed

(Signed) G. J. Haase M. D.

(Address) 2934 W. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 13 1929

20 UNDERTAKER George L. Schmidt ADDRESS 1101 Fulton Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E

49203 M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 3 E 49203

1-PLACE OF DEATH Gd. Gen Hosp. REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Kight.

(a) RESIDENCE No. Davis W. Va St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 2, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boy. Bad

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Davis - W. Va

PARENTS

10 NAME OF FATHER H. Kight.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Myrtle Nott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant (Address) Hospital

15 Filed SEP 13 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 21, 1929, to Sept 12, 1929,

that I last saw him alive on Sept 12, 1929,

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Brain Abscess.

(duration) yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Bacillus Meningitis

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 8/23/29

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Thos Thompson M. D.

(Address) Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Davis W. Va DATE OF BURIAL 9/13 1929

20 UNDERTAKER Harry A. Witzke ADDRESS 1531 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49204 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 49204

CERTIFICATE OF DEATH

1—PLACE OF DEATH CITY OF BALTIMORE (No.) South Baltimore General Hospital (St.) (Ward) REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Castagnera

(a) RESIDENCE NO. 6815 Brentwood Ave St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Maria Castagnera

6 DATE OF BIRTH (month, day, and year) Sept 15, 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A Morgan Co

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Eugene Castagnera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Pin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary Castagnera
(Address) 3611 Gunaning Ave

15 Filed PTS 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10-29

17 I HEREBY CERTIFY, That I attended deceased from 9-10, 19 29, to 9-10, 19 29, that I last saw him alive on 9-10, 19 29, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph Lauricella M. D.

19 (Address) South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	9/13 1929
20 UNDERTAKER	ADDRESS
[illegible]	1217 E Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

235186 E 49205 — 49 E 49205

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 27-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Anderson.

(a) RESIDENCE NO. 4112 St. Thomas Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Sarah

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Matilda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 13 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-10-29

17 I HEREBY CERTIFY, That I attended deceased from 9-5-, 1929, to 9-10-, 1929, that I last saw h~~im~~/alive on 9-10-, 1929 and that death occurred, on the date stated above, at 5 20 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Glioma, malignant

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 9/6/29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & autopsy

(Signed) Clarence B. Gardner Jr. M. D.

9/10, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Crem	9/13 1929
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Cathedral Baltimore

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49206 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 31 ✓

E 49206

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4-7 ST.) (WARD)

2—FULL NAME Joseph P Meyer

(a) RESIDENCE NO. Brookland Hills, Md. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 30 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laboring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph P. Myer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Addie J. Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mr. Joseph P Myer

(Address) 234 S. East ave

15 Filed 10 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 19 29, to Sept 10, 19 29 that I last saw h live on Sept 10, 19 29 and that death occurred, on the date stated above, at 8 55 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) J Feyko M. D.

(Address) Mercy Hospital

9/10, 19 29

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemtry	Sept 13 1929

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Balto St.

Important: See instructions on back of Certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49207

CERTIFICATE OF DEATH

1925 (90) E 49207

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 655 W Mulberry St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Marshall

(a) RESIDENCE NO. 655 W Mulberry St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jesse Lund

(Address) 655 W Mulberry St

15 Filed SEP 12 1929 Registrar

HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 12 1929, to Sept 12 1929, that I last saw him alive on Sept 12 1929 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Acute Gastritis (duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs mos 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Test

(Signed) J. T. Gunn M. D.

. 19 (Address) 522 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	9-13 1929
20 UNDERTAKER	ADDRESS 916
Dennis Estate	Pa ave

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Bks.

E 49208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 49208

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) Sinai Hospital ST. 2-4 WARD)

2-FULL NAME Mrs Bessie Williams

(a) RESIDENCE NO. 311 S. Ann ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theo. Williams

6 DATE OF BIRTH (month, day, and year): July 1898

7 AGE: Years 31 Months 2 Days 0 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Wm Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Lula Durham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Theo. Williams

(Address): 311 S. Ann St.

15 Filed ... 19 ... CHAMPION JONES, M. D. Registrar

Dec 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 9 , 1929 , to Sept 11 , 1929 , that I last saw her alive on Sept 11 , 1929 , and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

~~Retinal Tebopid~~

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (a) Heart failure

(duration) .3 yrs. mos. ds. (b) Myocarditis - probably rheumatic

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Benj Katz M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: Sept 15 1929

20 UNDERTAKER: Lilly & Julia Sue — ADDRESS: 110 E. Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 49209

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 S. Haven ST., 26-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie B Frei

(a) RESIDENCE NO. 122 S. Haven ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Frei

6 DATE OF BIRTH (month, day, and year): Aug 30 1864

7 AGE: Years 65 Months — Days 11 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Fetzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Kell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Frei

(Address) 122 S. Haven St

15 Filed Sept 19 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1929, to Sept 11, 1929, that I last saw h alive on Sept 11, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

CONTRIBUTORY (Secondary) Catarrhal Jaundice (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 10 ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Sod, M. D.

. 19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Sept 17 1929

20 UNDERTAKER: John Wenck — ADDRESS: 200 Wilkens

Spec.—2-23-28—L. F. S.—500 Blks.

22 6 12

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49210

CERTIFICATE OF DEATH

90

E 49210

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Ethel Coyle Carrington

(a) RESIDENCE NO. Tuscany Apartments ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 1 mos. 30 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Carrington

6 DATE OF BIRTH (month, day, and year) July 11th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Coyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Isabella Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 30, 1929, to September 10, 1929 that I last saw h.e alive on September 10, 1929 and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Myocarditis

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & laboratory

(Signed) R. Hoopes Smith, M. D.

Sept 14 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	Sept 13th 1929
20 UNDERTAKER Henry A. Jenkins Sons Co.	ADDRESS McCulloh & Eutaw Sts

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49211

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 McCulloh ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude V. Shipley

(a) RESIDENCE NO. 1221 McCulloh ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reece Shipley

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Wm N Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Martha Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Martha Smith

(Address) 1430 McCulloh St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 29

17 I HEREBY CERTIFY, That I attended deceased (from Sept 10, 1929, to Sept 11, 1929

that I last saw her alive on Sept 11, 1929

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis + Myocarditis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine etc

(Signed) H. Slaughter, M. D.

10/3, 19 29 (Address) 825 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	9/14, 19 29
20 UNDERTAKER Samuel D Beverley	ADDRESS 578 N Bridle

Important. See instructions on back of certificate.

1-3-1929 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

John R. Martin

E-49212 HEALTH DEPARTMENT—CITY OF BALTIMORE E-49212

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 2744 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John R. Martin

(a) RESIDENCE NO. 4921 Harford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mo. ds. How long in U. S., if foreign birth? 1 yr. 6 mo. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	~~Single~~ Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Alice M. Martin

6 DATE OF BIRTH (month, day, and year) May 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Penelope Mowing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Alice M. Martin

(Address)

15 Filed SEP 13 1929 C. HAMPSON JONES, By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 6, 19 29, to Sept 11, 19 29, that I last saw him alive on Sept 11, 19 29 and that death occurred, on the date stated above, at 6 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Post operative cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of prostate with metastases (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 7, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Physical sign

(Signed) Earl F. Lindbeck, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood.

DATE OF BURIAL 9/14 1929

20 UNDERTAKER L. Lehmann

ADDRESS 32. S Bway

Spec.—1-12-23—M&T—500 Bks.

E 49213 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-006 E 49213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (ST.) 7 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida Kirson

(a) RESIDENCE NO. 4546 Pimlico Rd (ST.) (WARD)
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer) 067
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Levy Kirson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Bessie Cureabon
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Kirson
(Address) Balto Md

Filed SEP 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 27 1929 to Sept 12th 1929.
that I last saw h[illegible] alive on Sept 12 1929
and that death occurred, on the date stated above, at 6 30 P.M.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) yrs. mos 15 ds.
CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Relay Maryland
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. F. Montagna, M. D.
, 19 (Address) 21 Bella Ave. Hagerstown.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Cem
DATE OF BURIAL 9/13 1929
20 UNDERTAKER Jack Lewis
ADDRESS 1434 E Balto

SEE INSTRUCTION is very important See instructions on back of certificates.

Spec.—1-10-21—M... Bks.

E 49214 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49214

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 325 WARD)

2-FULL NAME Isadore Goldberg

(a) RESIDENCE No. 130 Lloyd St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Goldberg

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis (Address) 1429 Balto.

15 Filed SEP 13 1929 C. HAMPSON JONES, M. D. By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10 1929 to Sept. 13 1929, that I last saw him alive on Sept. 13 1929, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension; chr. nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B.G. Cohen M. D.

9/13 1929 (Address) Sinai

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shaarai Tefilo DATE OF BURIAL 9-18-1929

20 UNDERTAKER Jack Lewis, 1439 ADDRESS E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Lots.

E 49215 John M. Szczepanski

HEALTH DEPARTMENT CITY OF BALTIMORE E 49215

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2223 Essex St. St., 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Szczepanski

(a) RESIDENCE NO. 2223 Essex St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John J. Szczeparski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Julia M. Muszynska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John J. Szczeparski

(Address) 2223 Essex St.

15 Filed ... 19 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 1929

17 I HEREBY CERTIFY, That I attended deceased from September 10, 1929, to Sept 12, 1929, that I last saw her alive on Sept 12, 1929, and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Ileo-colitis

(duration) yrs. Cans 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Laurd Jamieson M. D.

9/14, 1929 (Address) 2431 East Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Sept 13 1929

DATE OF BURIAL

20 UNDERTAKER John M Weber 401 S Chester

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49216

44

E49216

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Pennsylvania Ave. ST. 17-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eli Rosenthal

(a) RESIDENCE NO. 714 Pennsylvania. Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabelle Oppenheim Rosenthal

6 DATE OF BIRTH (month, day, and year) July 11th. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Levi Rosenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Eli Rosenthal

(Address) 714 Pennsylvania Ave

15 Filed SEP 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12th. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Sept 17, 1929, that I last saw him alive on Sept 12, 1929 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) I. Frederick Lentz, M. D.

9-17, 1929 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	9/13/ 1929

20 UNDERTAKER Maud Sondheim ADDRESS 1820 W. Mt. Royal Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49217 **HEALTH DEPARTMENT—CITY OF BALTIMORE** EE 49216 EE 49217

31

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 2-4 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Kucharsk

(a) RESIDENCE NO. 232 S. Ann st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? UNKNOWN yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Veronica Kucharsk

6 DATE OF BIRTH (month, day, and year) 1893 aprils

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	5	10.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel worker

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Frank Kucharsk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sophia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records
(Address)

15 Filed SEP 13 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1929, to Sept. 12, 1929, that I last saw him alive on Sept. 12, 1929 and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and Autopsy

(Signed) [illegible], M. D.

9-12, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Sept 17 1929
20 UNDERTAKER	ADDRESS
Martin W. C. Dipple Inc.	51 S Ann St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49218

CERTIFICATE OF DEATH

90

E 49218

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 N. Monroe ST. 16-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Holmes.

(a) RESIDENCE NO. 1005 N Monroe ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm G. Holmes.

6 DATE OF BIRTH (month, day, and year) Nov 26-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel D Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Wooten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Ethel Wooten

(Address) 1005 N. Monroe St

15 Filed ....., 19 .....

Registrar

D 13 1929

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.12.29.

17

I HEREBY CERTIFY, That I attended deceased from 9-10-, 1929, to Sept 12, 1929

that I last saw h[illegible] alive on Sept-12-, 1929

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marion W Stone M. D.

9-12-29, (Address) 806 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Park Cemetery	Sept 14-29
20 UNDERTAKER	ADDRESS
Kertam & Poe	1523 W Lafayette ave

Spec.—1-10-21—M&T—1500 Bks.

'E 49219 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49219

CERTIFICATE OF DEATH. STATE BIRTH NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 230 E. Heath ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Child of Mr. & Mrs. Chas. A. Gang

(a) RESIDENCE NO. 233 E. Heath ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 12/29

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.: 3 Minutes

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas. A. Gang

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Louise V. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Chas. A. Gang

(Address) 233 E. Heath St.

FILED SEP 13 1929 NATHAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 29, to Sept 12 1929.

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Stillborn

R.D.P. Presentation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. R. K. Campbell M. D.

Sept 13 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: Sept 13 1929

UNDERTAKER: Margaret A. Flynn

ADDRESS: 1422 Light St.

CAUSE OF DEATH in plain terms, so that if may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Carroll

E 49220

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 49220

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Wallemeyer ct ST., 15-21 WARD)

2-FULL NAME William Thomas Carroll

(a) RESIDENCE NO. 602 Wallemeyer ct ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hatter

(b) General nature of Industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER William Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Shell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Maggie Carroll

(Address) 602 Wallemeyer ct

15 Filed SEP 13 1929 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1929

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to Sept 11, 1929, that I last saw him alive on Aug 20, 1929, and that death occurred, on the date stated above, at 5301 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

9/12, 1929 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 9-13 1929

UNDERTAKER Geo W Chase & Son

ADDRESS 410 W Lex St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49221

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49221

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Valley ST. 10-14 WARD)

2-FULL NAME Catherine L. Steadman

(a) RESIDENCE NO. 1009 Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) June 16. 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: American Wholesale Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Edward J. Steadman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary E. Cain

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs. Mary E. Steadman (Address): 1009 Valley St

15 Filed SEP 13 1929 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1929, to Sept. 13, 1929, that I last saw her alive on Sept. 1, 1929, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Intestinal Tuberculosis

About (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Sputum

(Signed) Thos. H. Pearson, M. D.

, 19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept 16 '29
UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E. Eager St.

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49222
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-001

E 49222
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; IN Garrison & Windsor Aves Windsor Court Apts 5-61 WARD

2-FULL NAME Margaret C. Cook

(a) RESIDENCE No. Garrison & Windsor Aves WARD
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23-1852

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Fredrick Cook
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md
12 MAIDEN NAME OF MOTHER: Eliza Devan
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Victor L. Cook
(Address) 3412 Georgia Ave Baltimore Md

15 Filed SEP 13 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 18. 1929. to Sept 12 1929.
that I last saw h[illegible] alive on Sept 11 1929
and that death occurred, on the date stated above, at [illegible]. 30 m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. mos. ✓ ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? [illegible] Date of
Was there an autopsy? [illegible]
What test confirmed diagnosis? Clinical
(Signed) [illegible] M. D.
(Address) 615 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery DATE OF BURIAL 9/14 1929
20 UNDERTAKER: Chas. R. Mauchson ADDRESS 1 W. Mt Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Brady

E 49223 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 49223

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 N. Fulton Ave., ST. 11-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph E. Brady

(a) RESIDENCE NO. 30 N. Fulton Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 28, 1868

7 AGE	Years	Months	Days (3)	If LESS than 1 day, hrs. or min.
	61	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James H. Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Rose A. Golden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Annie Brady

(Address) 30 N. Fulton Ave.,

15 Filed SEP 13 1929 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 25th, 19 29, to September 10, 19 29, that I last saw h im alive on September 10, 19 29 and that death occurred, on the date stated above, at 215 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mns. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs 6 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/10/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Co-Pleasing, M. D.

9/12 19 (Address) 32 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 9/14 1929

20 UNDERTAKER: Robert F. Graue & Son 11 W. Mt. Royal — ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

E 49224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 49224

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 10-14 ST. WARD)

2-FULL NAME Mrs. Sarah Lilley

(a) RESIDENCE No. 140 E. Chase St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Lilley

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS:

10 NAME OF FATHER Joshua Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant H. C. Rockenstein

(Address) 1402 E. Chase St

15 Filed SEP 13 1929 19 HAMPSON GORES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Sept 11, 1929, that I last saw her alive on Sept 11, 1929, and that death occurred, on the date stated above at 7:40 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast Broncho-pneumonia

Suppurative Mastitis, left

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis - Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Aug 14, 1929

Was there an autopsy? Yes.

What test confirmed diagnosis? Path Microscopic

(Signed) Benj. M. Cole, M. D.

19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wheelerville Md — DATE OF BURIAL Sept 13 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Price ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49225

CERTIFICATE OF DEATH. X 46

E 49225

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 N. Durham Alley St. 11-24 WARD)

2-FULL NAME Mrs. Mary Price.

(a) RESIDENCE No. Back Bay St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Raymond Price

6 DATE OF BIRTH (month, day, and year) Feb. 26. 1896.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife (in)

(b) General nature of industry, business, or establishment in which employed (or employer) Cat Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Back Bay Md.

PARENTS

10 NAME OF FATHER Arthur Moore.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rock Hall Md

12 MAIDEN NAME OF MOTHER Emma Downing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Back Bay Md.

14 Informant Hospital Records (Address)

15 Filed SEP 13 1929 CHAMPION JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12/29

17 I HEREBY CERTIFY, That I attended deceased from 9/9/29, 19..., to 9/12/29, 19...

that I last saw h[illegible] alive on 9/12/29, 19...

and that death occurred, on the date stated above, at 12 oc P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9/12/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	9/13 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49226

185 ✓

E 49226

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hosp. Ward) 16-64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Emerine

(a) RESIDENCE NO. 715 Poplar Grove St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pete Emerine

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
70 yrs	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H W 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Mary Brotherhood
(Address) 2838 W Lanvale

15 Filed ....., 19.... E. HAMPSON JONES, M. D. Registrar

SEP 13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Fracture L. R. Femur

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D.

9/12, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	9/14 1929
20 UNDERTAKER William Cook	ADDRESS St. Paul & Preston

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

o.—100 Bks.

E 49227 DEPARTMENT—CITY OF BALTIMORE E 49227.

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

City of Baltimore: (No.) Md Genl Hosp St. W-71 (Ward)

2-FULL NAME John H Phillips

(a) RESIDENCE NO. 4229 Potter St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Phillips

6 DATE OF BIRTH (month, day, and year): Dec 9 1871

7 AGE: Years 57 | Months 9 | Days 2 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Mr Coplin

9 BIRTHPLACE (city or town)
(State or country): Ill.

PARENTS

10 NAME OF FATHER: John H Phillips

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Unknown

14 Informant: Mrs Rose Phillips
(Address): 4229 Potter St

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows*

Acc Fall Down!
Fracture of Skull
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock
(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What tests confirm diagnosis? History

(Signed) H C Wades, M. D.

, 19 (Address) 1430 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 9/14 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 E Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E49228 · HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E49228

31

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1422 W. Lanvale ST. 6-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude N. Phillips

(a) RESIDENCE NO. 1422 W. Lanvale ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillips

6 DATE OF BIRTH (month, day, and year) Aug 10 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public 68

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Thos H Neal

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Smith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Jennie B Neal
(Address) 1422 W Lanvale

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11-1929

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to Sept 11-, 1929, that I last saw h.. alive on Sept 10-, 1929 and that death occurred, on the date stated above, at 10.05 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys. exam

(Signed) Chas J Keller, M. D.

9/13/1929 (Address) 222 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9/14/29
20 UNDERTAKER	ADDRESS
Frank T Kemler	578 N Bidle

Important. See instructions on back of certificates.

P13 1929 HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49229

CERTIFICATE OF DEATH. X 11 E 49229

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST., 11-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Muhlbauer

(a) RESIDENCE NO. Hazel & Wash. Ave., ST., Towsontown WARD Md.
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. 6 ds. How long in U. S., if of foreign birth? [illegible] yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Mr. Muhlbauer

6 DATE OF BIRTH (month, day, and year) May 15th 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Frank Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Hospital records

15 FILED SEP 13 1929 J. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/6, 1929, to 9/12, 1929.

that I last saw her alive on 9/12, 1929.

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix.

Generalized peritonitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) General septicaemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 9/6/29

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D.

, 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 14, 1929

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49230

CERTIFICATE OF DEATH.

31

E 49230

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. 3711 Elm ave. St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Marie Parks

(a) RESIDENCE NO. 3711 Elm Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. — mos. ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1-1909.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	20	—	11 da.	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Saleslady. 67

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Chestnut Ridge

(State or country) Balto Co., Maryland.

PARENTS

10 NAME OF FATHER John Franklin Parks.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Co., Md.

12 MAIDEN NAME OF MOTHER Martha Corkey.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Co. Maryland.

14 Informant Virginia Lovett.

(Address) 36 Pa. Falls Rd.

15 Filed SEP 13 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12-1929.

17

I HEREBY CERTIFY, That I attended deceased from August 19- 1929, to September 12, 1929, that I last saw her alive on Sept 12- , 1929, and that death occurred, on the date stated above, at 1:17 P. m.

The CAUSE OF DEATH* was as follows:

Drinking Tuberculosis

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum & Physical Signs

(Signed) Chester Ruland, M. D.

9-12-1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Mary's Cemetery Hamden 9/14 1929

20 UNDERTAKER — ADDRESS

John Burns Sons Towson Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49231

CERTIFICATE OF DEATH

E 49231

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4014 Bellwood Ave, 27-41 WARD)

2—FULL NAME John Morris Hall

(a) RESIDENCE NO. 4014 Bellwood Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence A. Hall

6 DATE OF BIRTH (month, day, and year): Feb 12 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter. 015

(b) General natore of indostry, bosiness, or establishment in which employed (or employer): Con. Eng. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Kincade

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Florence Hall

(Address): 4014 Bellwood Ave

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

9/3/1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 11 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1929, to Sept 11, 1929, that I last saw h[illegible] alive on Sept. 11, 1929 and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel B. Wolfe, M. D.

Sept 13, 1929 (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 14, 1929
20 UNDERTAKER: Wellain Cook	ADDRESS: 2127 E Pratt St

Spec.—1-12-23—M&T—500 Blks.

E 49232 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49232

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2821 Georgetown Rd ST.) (W. WARD) 25-72

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence A Tarum

(a) RESIDENCE No. 2821 Georgetown Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
		3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER A. Wessel Tarum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Helen L Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant A Wessel Tarum

(Address) 2821 Georgetown Rd

15 Filed SEP 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 19 , to Sept 13, 1929

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Uremia - coleb

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 2 (Address) Parkelands

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 14, 1929
20 UNDERTAKER	ADDRESS
John F Denny	715 [illegible]

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 49233

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 8-01

E 49233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 15-68 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cohen

(a) RESIDENCE NO. 2419 Woodstock ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17 1928

7 AGE: Years 1 Months 1 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Md

PARENTS

10 NAME OF FATHER: Morris Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia Poland

12 MAIDEN NAME OF MOTHER: Bessie Caplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Laurs

(Address) 1439 E Balto St

15 Filed 1 3 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Sept 13, 1929.

that I last saw him alive on Sept 13, 1929,

and that death occurred, on the date stated above, at 11 35 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar,

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Rickets - Scurvy.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Obs. X-ray

(Signed) M J Cohen, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Intd Asmd

DATE OF BURIAL: 9/13 1929

UNDERTAKER: Jack Laurs

ADDRESS: 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49234

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vernon Miller

(a) RESIDENCE NO. Loch Raven Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Myra Wilcox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

11 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 13 1929, 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-13/29

17 I HEREBY CERTIFY, That I attended deceased from August 29, 1929, to Sept 13, 1929, that I last saw him alive on Sept 13, 1929 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) — yrs. — mos. 24 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Loch Raven, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Hedwig Koenig, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North Wilkesburgh	Sept 15th 1929
20 UNDERTAKER	ADDRESS
John Burns Sons N. Carolina	Towson Md

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49235

CERTIFICATE OF DEATH

E 49236

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5502 Merrille Ave Ward 27-15)

2-FULL NAME Franklin O. Pfoutz

(a) RESIDENCE NO. 5502 Merrille Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L Pfoutz

6 DATE OF BIRTH (month, day, and year) Oct 23 1866

7 AGE Years	Months 10	Days 20	IF LESS than 1 day ... hrs. or ... min.
62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co
(State or country) Md

PARENTS

10 NAME OF FATHER John Pfoutz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Repp

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Anna Pfoutz
(Address) 5502 Merrille ave

15 Filed ..... 19 .....
Registrar

1 4 1929 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, (Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Disease
Heart
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Wesselius M. D.

(Address) 9672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Sept 14, 29
20 UNDERTAKER	ADDRESS
John O Mitchell & Son	1458 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49236

1—PLACE OF DEATH

REGISTERED NO. 27-53 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3515 Hayward Ave ST., 27 WARD)

2—FULL NAME Howard J. Watts

(a) RESIDENCE NO. 3515 Hayward Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER John J. Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Margaret Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant John J. Watts (Address) 3515 Hayward Ave

15 Filed 19 C. THAMPSON JONES, M.D. Registrar

141929 BM RBM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12, 1929.

17

I HEREBY CERTIFY, That I attended deceased from May, 1929, to Sept 12, 1929.

that I last saw him alive on Sept 12, 1929

and that death occurred, on the date stated above, at 7:25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds. (4 years)

CONTRIBUTORY (Secondary) Ulceration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inspection

(Signed) Henry Neufeld M. D.

9-13-1929 (Address) 3902 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Cemetery	Oct 15 1929
20 UNDERTAKER	ADDRESS
C Hinowitz & Son	

Important: See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49237 E 49237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 Pemberton 4-54 WARD) REGISTERED NO. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Francis

(a) RESIDENCE NO. 511 Pemberton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Francis

6 DATE OF BIRTH (month, day, and year): August 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63		27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: /

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Robt Burch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Maggie Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Lydia Lovett

(Address): 511 Pemberton Ave

15 1 4 1929 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/11/ 1929

17 I HEREBY CERTIFY, that I attended deceased from 7/11/ 1929, to 9/11/ 1929

that I last saw h alive on 9/11/ 1929, and that death occurred, on the date stated above, at 7.40 A.M.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

9/12, 1929 (Signed) A. Lee Ellis, M. D.

(Address) 524 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 14 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	303 Fiesstman St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 V

E 49238

1—PLACE OF DEATH

REGISTERED NO. 16-33

CITY OF BALTIMORE: (No. 1118 N. Carey St. ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maggie Perkins

(a) RESIDENCE NO. 1118 N. Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Perkins

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alexander Amby.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Elizabeth Cassoway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md.

14 Informant Elizabeth Stoval

(Address) 1118 N. Carey St.

15 Filed 1 4 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13-29

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to Sept. 13, 1929, that I last saw her alive on Sept. 12, 1929 and that death occurred, on the date stated above, at 1;30a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

(Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 16 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 307 Presstman St

IMPORTANT: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49239

177 E 49239

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 6-9 Ward)

2-FULL NAME Marie W. Prettyman

(a) RESIDENCE NO. 306 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----- Prettyman.

6 DATE OF BIRTH (month, day, and year) Jany 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or .... min.
	29	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Salisbury, Md.

PARENTS

10 NAME OF FATHER Daniel Bradley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Salisbury, Md.

12 MAIDEN NAME OF MOTHER Mary L. Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Salisbury, Md.

14 Informant Daniel Bradley
(Address) Salisbury, Md.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 11/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning
(Probably Accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? Yes at Hopkins Hospital

What test confirmed diagnosis?

(Signed) J. S. Gallman, M. D.

9/13/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Sept 14 1929
20 UNDERTAKER	ADDRESS
Geo M Fink & Son	2118 Wolfe

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

Collmus

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 49240

E 49240

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1730 Ellamont Street St. 15-67 Ward)

2-FULL NAME Marian Patton Collmus

(a) RESIDENCE NO. 1730 Ellamont Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? 73 yrs. 6 mos. 24 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert S. Collmus

6 DATE OF BIRTH (month, day, and year) February 19, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Shaw

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marrian Patton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr. Robert S. Collmus (husband)

(Address) 1730 Ellamont Street.

15 Filed ..... 19 ..... Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uterine Sclerosis

Mitral Stenosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Radcliffe M. D.

(Coroner)

, 19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 30 yrs., 0 mos., 0 ds. In the State 73 yrs., 6 mos., 24 ds.

Where was disease contracted, if not at place of death? 1730 Ellamont Street

Former or usual residence 1730 Ellamont Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn Cemetery	19

20 UNDERTAKER STEWART & [illegible] COMPANY (WILLIAM F. STEWART, President)

ADDRESS 108 W. NORTH AVE

G. HAMPSON JONES, M. D.

SEP 14 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49241 31 **E 49241**

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 192 Chadstaine St., 8-17 Ward)

2-FULL NAME Mary Morton

(a) RESIDENCE NO. 192 Chadstaine St., _____ Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	C.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Jan 16 1913

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	16	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Hunter Morton

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Stokes

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Va.

14 Informant Mary Morton
(Address) 1921 Chadstaine

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows*

Lobar Pneumonia

(duration) 1 yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secundary) Ca Lawston

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? —

Did accident operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) G. C. Hampson Jones M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Oct 14 29
20 UNDERTAKER	**ADDRESS**
Mrs. P. G. Elliott	1725 Eastland Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 49242 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 801 E 49242

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 N. Charles ST. 11-15 WARD)

2-FULL NAME Virginia Jordan Harvey

(a) RESIDENCE NO. 936 N. Charles ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of widow William P. Harvey

6 DATE OF BIRTH (month, day, and year) Jan 7th 1845

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Allegheny Pennsylvania

PARENTS

10 NAME OF FATHER Wm Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Wm E. Harvey

(Address) 936 N Charles St

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

14 1929 RKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1926, to Sept 13, 1929, that I last saw h[illegible] alive on Sept 13, 1929 and that death occurred, on the date stated above, at 10 a m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3½ ds.

CONTRIBUTORY (Secondary) Cerebral arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Hobart A. Reed, M. D.

9/14, 1929 (Address) 1403 Park av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 9/16 1929

20 UNDERTAKER Henry W. Jenkins' Sons Co

ADDRESS Richard McCulloh

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49243 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49243

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 10-13 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Krick

(a) RESIDENCE NO. 1406 Anthony ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Krick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Carrie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed SEP 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from November 29, 1926, to September 12, 1929 that I last saw h... alive on September 12, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Fatal

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home (duration) 3 yrs. mos. ds.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Heart PC

(Signed) Marion M. McLean, M. D.

9-13, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL SEP 14 1929

20 UNDERTAKER Henry Koch & Sons Inc. ADDRESS 1301 E Eager St

Spec.—12-9 25—A Co.—200 Bks.

E 49244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 49244

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 E Fort Ave St. 24-33 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phyrtle Wagner

(a) RESIDENCE NO. 714 E Fort Ave St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, ~~Married, Widowed~~, or Divorced, (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6. 22 1911

7 AGE — Years: 18 — Months: 2 — Days: 20 20 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto City

(State or country)

PARENTS

10 NAME OF FATHER: Frank Wagner

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER: Ella Hartlove

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Frank Wagner

(Address): 714 E Fort ave

14 SEP 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 12 1929

17 I HEREBY CERTIFY, That I attended deceased from 9. 9. 1928, to 9. 12 1929, that I last saw her alive on 9. 12 1929, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burlington, M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. — Date of Burial: 9/16 1929

20 UNDERTAKER: S. Few McCully — ADDRESS: 130 E. For

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49245

CERTIFICATE OF DEATH.

E 49245

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. ST. 16-66 WARD) 7K-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Hamilton

(a) RESIDENCE No. 502 Normandy Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Daisie Hamilton

6 DATE OF BIRTH (month, day, and year) May 2 - 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	- 4	- 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas A. Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Allentown Penn

12 MAIDEN NAME OF MOTHER Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Hospt Records

15 1 4 1929 C. HAMPSON JONES, M. D. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12 1929

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to September 12, 1929, that I last saw him alive on September 12, 1929, and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

(duration) Unknown da.

CONTRIBUTORY (Secondary) Intracranial hemorrhage

(duration) yrs. 1 mos. 25 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

Were there any tests? Spinal puncture. Negative

(Signed) [illegible] M. D.

(Address) Mary Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 9/16/29

20 UNDERTAKER Geo Lembeck — ADDRESS 2211 N Lyndhurst St

Spec.—2-29-28—L. F. S.—500 Bks.

2249 E 49246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

147 E 49246

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Myers (Mrs.) Elliott

(a) RESIDENCE NO. 1049 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Elliot

6 DATE OF BIRTH (month, day, and year) 9/20/99

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~29~~ 29 Yrs.	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-12-1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Sept 12, 1929, that I last saw her alive on Sept 12, 1929 and that death occurred, on the date stated above, at 3.19 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Yes.

(Signed) Herbert T. Grant, M. D.

9/12, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery — DATE OF BURIAL Sept 14, 1929

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 3227 W. Lafayette St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49247

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. S/S Munmotor, Foot of Hull St. St., 24-35 Ward)

2-FULL NAME Arnold Giesemann Jr.

(a) RESIDENCE NO. 214 5th St. Ridgefield, N. J. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced, HUSBAND of Minina A. Giesemann.

6 DATE OF BIRTH (month, day, and year) May 28 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	41	3	21 20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 1st Asst. Eng. 30
(b) General nature of industry, business, or establishment in which employed (or employer) S/S Munmotor. 0
(c) Name of employer

9 BIRTHPLACE (city or town) New Jersey.
(State or country)

PARENTS

10 NAME OF FATHER Arnold Giesemann Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York.

12 MAIDEN NAME OF MOTHER Sally Coons.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio.

14 Informant Minina A. Giesemann. (wife)
(Address) 214 5th St. Ridgefield, N. J.

15 Filed ..... 1929 C. HAMPSON JONES, M. D. Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) September 13, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt M. D.

9/14. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York Cemetery Rockaway N. J.

DATE OF BURIAL: Sept 14 192

20 UNDERTAKER: John P. Denny

ADDRESS: 1 S Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49248

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-002 E 49248

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST. 27-43 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Carter

(a) RESIDENCE NO. 6200 Harford Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5 | 28 | 29

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
		3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Hugh W. Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Marie A. Tommal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Hugh W Carter

(Address) 6906 Harford Road

15 4 1929 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/29

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1929, to April 12, 1929.

that I last saw him alive on April 12, 1929.

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery one wk,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Trauma

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M Blundy, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	9/14 1929

20 UNDERTAKER George J. Ruth Inc. ADDRESS 135 Harford Avenue

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49249 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 49249**

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2805 Remington ST., 12-51 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosie Bishop

(a) RESIDENCE NO. 2805 Remington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Fem	C.	Widow

a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Ralph Bishop

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maria Redman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Louise Price

(Address) 2805 Remington Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1927, to Sept 12, 1929.

(that I last saw her alive on Sept 12 1929

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

Contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) D. Garland Cornell M. D.

9/13 1929 (Address) 534 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Sept 15 1929

20 UNDERTAKER Wm. H. Chase & Son — ADDRESS 1405 Madison

Important. See instructions on back of certificates.

SEP 14 1929 G. HAMPSON JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

Engellers

122-101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49250

E 49250

REGISTERED NO.

7—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ada Brocato

(a) RESIDENCE NO. 643 W. Fayette ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 mos. ds. How long in U. S., If foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel J Brocato

6 DATE OF BIRTH (month, day, and year): May 13th 1889

7 AGE: Years 40 | Months 4 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): House work

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Smith Anna.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: patient

(Address) 643 W Fayette St.

15 Date: 1 5 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 13th 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 12 . 1929. to Sept 13 . 1929. that I last saw her alive on Sept 13 . 1929 and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver
Ascites

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage Internal Ruptured Varix Esophageal. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) H Glenn Speicher M. D.

(Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pen Lenn Md

DATE OF BURIAL: Sept 15 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

Important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 49251

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 49251

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 33 S Bond St. 3-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Smith

(a) RESIDENCE NO. 33 S. Bond St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Smith

6 DATE OF BIRTH (month, day, and year): May 1 1890

7 AGE: Years 39 Months 4 Days 11

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Jenkins Farm Weldon N.C.

9 BIRTHPLACE (city or town) (State or country): Weldon N.C.

PARENTS

10 NAME OF FATHER: Bobby Pilbam

11 BIRTHPLACE OF FATHER (City or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Martha Baker

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Weldon N.C.

14 Informant: Mamie Kenny

(Address): 33 S. Bond St

15 Filed SEP 15 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: September 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 19 29, to Sept 12, 19 29,

that I last saw h[illegible] alive on Sept 12, 19 29,

and that death occurred, on the date stated above, at 3.25 PM

The CAUSE OF DEATH* was as follows:—

Hemorrhage

Hemiplegia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Probably Rheumatism

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) R. L. Cushing M. D.

19 (Address) 1814 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetery — Date of Burial: Sept 15 1929

20 UNDERTAKER: Milton Davis — ADDRESS: 413 N Eden St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49252 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49252

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General [illegible] 3 (Street) (Ward) 129 ✓

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John Lentz

(a) RESIDENCE NO. 4400 Thornton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec 15/1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
67	8	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Lentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John H Lentz

(Address) 4400 Thornton Ave

15 Filed SEP 15 1929 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 11 1929 to Sept 14 1929

that I last saw him alive on Sept 14 1929

and that death occurred, on the date stated above, at 6.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic glomerulo nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical and laboratory.

(Signed) J. Calogna, M. D.

, 19 (Address) W. Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery DATE OF BURIAL: Sept 16 1929

20 UNDERTAKER: Harry H Armacost ADDRESS: 4204 Reisterstown Rd

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 49253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

001

6 E 49253

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 Brantley ST. 16-26 (WARD)

2-FULL NAME Martha Gibson

(a) RESIDENCE NO. 1012 Brantley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Gibson

6 DATE OF BIRTH (month, day, and year) 9/12/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Robert Alex Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Edna E. Gosnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Agnes Gibson

(Address) 1012 Brantley

15 Filed SEP 15 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14 1929

17

I HEREBY CERTIFY, That I attended deceased from 9/12, 1929, to 9/14, 1929, that I last saw her alive on 9/13, 1929, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Premature - Twin (6½ mo. pregnancy).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) David Grayken, M. D.

9/17 19 29 (Address) 1212 W Lee St —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL Sept 18 29

20 UNDERTAKER Samuel Hawley ADDRESS Dr Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1855

E 49254
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Declared dead at St. Joseph Hospital St., 10-15 Ward)

2-FULL NAME Charles Moffett

(a) RESIDENCE NO. 415 E. Chase St., Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Moffett

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Police Records
(Address)

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 13/29 192

17 I HEREBY CERTIFY, That I took charge of the remains deserihed above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Probably Intracranial Injury
Accidently fell down stairs in his residence

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What lesl confirmed diagnosis?
(Signed) [signature] M. D.
9/14/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick md — DATE OF BURIAL: Sept 17 29

20 UNDERTAKER: Samuel Hemsley — ADDRESS: 578 N Bond

RLH

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-001

E 49255

CERTIFICATE OF DEATH

E 49255

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Ritzel

(a) RESIDENCE NO. 1752 Orleans ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Mar 24/82 Baltimore

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Broom Manf'g.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Ritzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Irwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed ....., 19 .... Registrar

SEP 15 1929 JAMES H. JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/13/29

17 I HEREBY CERTIFY, That I attended deceased from 7/26, 1929, to 9/13, 1929, that I last saw him alive on 9/13, 1929 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Post operative collapse

(duration) yrs. mos. 1 hr.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 9/13/29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) A. O. Pumphrey, M. D.

9/14, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem

DATE OF BURIAL 9/16, 1929

20 UNDERTAKER Philip Herwig

ADDRESS 206 Orleans st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49256

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 49256

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1613 Chilton St ST. 8-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ferdinand Vetter

(a) RESIDENCE NO. 1613 Chilton St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma H. Vetter

6 DATE OF BIRTH (month, day, and year) Jan 9/1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Designer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Fred. Vetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Siegmund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hannah Vetter

(Address) 1613 Chilton St.

15 Filed SEP 15 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13/29

17 I HEREBY CERTIFY, That I attended deceased from May - 1927 1929, to Sept - 10, 1929, that I last saw h— alive on Sept 10 - 1929 and that death occurred, on the date stated above, at 6.25 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Dis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

Senility (duration) yrs. mos. 1/2 Hr.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Frank A Krause M. D.

19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Sept 17 19 29

20 UNDERTAKER Philip Henig

ADDRESS 2016 Orleans St.

Cor.—12-9-25—A Co.—200 Bks.

E 49257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001

E 49257

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Lucy Hospital's St. [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julius Schaaf

(a) RESIDENCE NO. 3725 Gough St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 10 79

7 AGE — Years: 50 — Months: 6 — Days: 2 3 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon

(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER John Schaaf

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Hupka

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Louis Trischmann

(Address) Phila rd near Hamilton ave

15 Filed ..... 19 ..... Registrar

E [illegible] 1929 EDWARD JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Bruises & probable Fracture of Skull

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

Sept 29/29 [illegible] Gladest M. D.

(Coroner)

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — Date of Burial: 9/15 1929

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49258 — 1—PLACE OF DEATH — REGISTERED NO. E 49258

CITY OF BALTIMORE: (No. University Hospital W. 18-N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Goldwine

(a) RESIDENCE NO. 847 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Goldwine

6 DATE OF BIRTH (month, day, and year) ? 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Goldwine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Elezabeth Savkitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant B. Goldwine

(Address) 847 Hollins St.

15 Filed SEP 15 1929 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 19 29, to Sept 13, 19 29, that I last saw h alive on Sept 13, 19 29 and that death occurred, on the date stated above, at 1:15 p m.

The CAUSE OF DEATH* was as follows:

~~Intestinal Obs~~

Duodenal ulcer.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforating ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Sept. 12-1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. C. Pantuliano, M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept. 16. 1929
20 UNDERTAKER	**ADDRESS**
John Grebliauckas	428 S Paca St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49259 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 49259

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Clifton ave ST., 15-66 WARD)

2—FULL NAME Minnie Zimmerman

(a) RESIDENCE NO. 3710 Clifton ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

6a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Hyman Zimmerman

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years 80; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: old age
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Samuel Rothman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Antown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Morris Zimmerman
(Address) 3710 Clifton ave

15 Filed SEP 15 1929 19 G. HARRY JONES, M. D. Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-13-29

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Sept 13, 1929, that I last saw h Er alive on Sept 13, 1929, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Terminal)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Myocarditis, Cardiac dilation, Senile degeneration

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph Gichner, M. D.

Sept 14, 1929 (Address) 320 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northern Cem

DATE OF BURIAL: 9/15 1929

20 UNDERTAKER: Jack Lewis & Co

ADDRESS: Balto

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49260

CERTIFICATE OF DEATH.

23 E 49260

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST. (WARD)

2-FULL NAME Elizabeth Smith

(a) RESIDENCE No. 528 Brice ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	6	7.	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George N. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Carrie Geller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant George N. Smith (Address) 528 Brice

15 Filed SEP 15 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10 1929 to Sept 13 1929

that I last saw h alive on Sept 13 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Spinal puncture.

(Signed) S. F. Hess M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Sept 16 1929
20 UNDERTAKER Charles H Kuhner	ADDRESS 532 Hollins

HON is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49261

CERTIFICATE OF DEATH.

113

E 49261

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hosp.

City of BALTIMORE: (No. ~~1243 S. Decker Ave~~ St., 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edmund Linnskie

(a) RESIDENCE NO. 1243 S Decker Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): D.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24 1929

7 AGE: Years / Months 4 / Days 19. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Wm Linnskie

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto.

12 MAIDEN NAME OF MOTHER Anna Mintek

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto.

14 Informant Wm Linnskie

(Address) 1243 S. Decker Ave.

15 Filed SEP 15 1929 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 13/29 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Indigestion

(Autopsy at Hopkins)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ricketts?

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Mateer M. D.

(Coroner)

9/14/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. Date of Burial: Sept. 16, 29

20 UNDERTAKER: Stephen J. Fiatkowski ADDRESS 1003 S. Konwent ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49262

CERTIFICATE OF DEATH.

66

E 49262

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Marine Hosp. St. 27-44 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Fawcett

(a) RESIDENCE NO. Rosekempave Hamilton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 30

(c) Name of employer

9 BIRTHPLACE (city or town) Scotland

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant John Lipsack

(Address) 2840 Elliott st

15 Filed 19 HANSON HOOKS M. D. Registrar

SEP 15 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Alcoholism Poisoning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Thompson M. D.

Coroner

9/14, 1929 (Address) John Thompson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Oak Lawn Cem	Sept 16 1929

20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski Jr	1000 S. Haven

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 49263

Co. Form No. 4 A Co.—100 Bks.

John Meinschein

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 49263

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary St. 6-9 Ward)

2-FULL NAME John Meinschein

(a) RESIDENCE NO. Orchard Beach, A.A.Co. Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Meinschein

6 DATE OF BIRTH (month, day, and year) Jan 30/1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Processor
(b) General nature of industry, business, or establishment in which employed (or employer) Canning House
(c) Name of employer Fleming & Co

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael Meinsche n

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Mauns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary L. Meinschein
(Address) 205 W. West St.

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

SEP 15 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 13/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis--Intestinal Obstruction.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum.

(duration) ? yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of 9/12/29

Was there an autopsy? yes at Church Home

What test confirmed diagnosis?

(Signed) J. H. Cotton, M. D.

9/14/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 16 1929
20 UNDERTAKER	ADDRESS
E. Schlemmer & Son	Hanover

1929 S1

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49264

CERTIFICATE OF DEATH.

84 E 49264

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (St.) 27-55 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Frances King

(a) RESIDENCE NO. 2896 Manhattan Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willis M. King

6 DATE OF BIRTH (month, day, and year) March 15 1892

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	5	24 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Francis Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Eurich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records

15 Filed . 19 . C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3 . 1929 . to Sept 12 . 1929 . that I last saw him alive on Sept 12 . 1929 . and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Neoplasm of the Right frontal lobe (classification undiagnosed) of brain (duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) cerebral pressure and surgical shock (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/12/29

Was there an autopsy? No

What test confirmed diagnosis? Ventriculography

(Signed) [illegible] M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlestown Cem. Cecil Co. Md.	Sept 15 19 29
20 UNDERTAKER	ADDRESS
Mrs Margaret A. Flynn	1722 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49265 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49265

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1371 Aude ST. 24-35 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin Palzin

(a) RESIDENCE NO. 1371 Aude ST.

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Maire Palzin

6 DATE OF BIRTH (month, day, and year) Oct 7-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	11	22 6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Godfrey Palzin

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Germany. (State or country)

14

Informant Amand L. Palzin

(Address) 1371 Aude St

15

Filed SEP 15 1929 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13-1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 7. 1929. to Sept 13. 1929.

that I last saw him alive on Sept 12. 1929.

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Arteriosclerosis, Hypertension

and Chr. Interstitial Nephritis

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 7 ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Jones, M. D.

9/14. 1929 (Address) 2578 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. A A

DATE OF BURIAL Sept 16 1929

20 UNDERTAKER Margaret L. Flynn

ADDRESS 6432 Eight

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49266

CERTIFICATE OF DEATH

90 ✓

E 49266

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 516 N. Castle St. WARD 9)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lohmann

(a) RESIDENCE NO. 516 N. Castle ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (Write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George A. Lohmann

6 DATE OF BIRTH (month, day, and year): Nov 3-1851

7 AGE: Years 77 | Months 10 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): German

PARENTS

10 NAME OF FATHER: Deist

11 BIRTHPLACE OF FATHER (city or town) (State or country): German

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): German

14 Informant: Marie Frost

(Address) 516 N. Castle St.

15 Filed ..... 19 .....

OCT 5 1929 C. HAMPSON CONTE ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-12-29

17 I HEREBY CERTIFY, That I attended deceased from 8-1-29 to 9-12-29

that I last saw h... alive on 9-12-29

and that death occurred, on the date stated above, at 6 15 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

1½

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. Reuss M. D.

Sept 11, 19 29 (Address) 500 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemtry.

DATE OF BURIAL: Sept 16 1929

20 UNDERTAKER: John A. Moran

ADDRESS: 3100 E. Baltimore

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49267

CERTIFICATE OF DEATH.

90 E 49267

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital WARD 11-24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grant Witmeyer

(a) RESIDENCE No. 619 E Baltimore St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar making shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rapho Township Lancaster Co., Pa

PARENTS

10 NAME OF FATHER Henry S Witmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rapho Township, Lancaster Co., Pa

12 MAIDEN NAME OF MOTHER Anna Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rapho, Lancaster Co., Pa.

14 Informant (Address) Hospital Records

15 Filed ... 19 ... Registrar

P 5 1929 G. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1929, to Sept 14, 1929, that I last saw him alive on Sept 14, 1929, and that death occurred, on the date stated above, at 6.40 A.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis with decompensation.

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. A. Townsend M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manheim Pa — DATE OF BURIAL Sept 16 1929

20 UNDERTAKER John F Denny — ADDRESS 705 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49268 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 49268
REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Altamont Hotel St. 11-27 WARD)

2—FULL NAME Julius Hines

(a) RESIDENCE NO. Altamont Hotel ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ricka Hines

6 DATE OF BIRTH (month, day, and year) Sept. 28 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Bkd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Ricka Hines (Address) Wash. D.C.

15 Filed SEP 6 1929 H. Robt. JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14/29.

17 I HEREBY CERTIFY, That I attended deceased from Jan —, 1929, to Sept. 14, 1929, that I last saw him alive on Sept. 14, 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual Laboratory Test

(Signed) Joseph W. Kelly, M. D.

19 (Address) 1207 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak. Shulom'n.	9/16/ 1929
20 UNDERTAKER Harris Stuchin	ADDRESS 410-20 W. Mt. Royal Ave

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49269 12894 8

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 129 E 49269

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Feinstein

(a) RESIDENCE NO. 114 Bader Ave ST., WARD Atlantic City, NJ

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Goldie Feinstein

6 DATE OF BIRTH (month, day, and year) about 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer) self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nadore Feinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Reichentin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 16 1929, 19 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1929, to Sept 15, 1929, that I last saw h.. alive on Sept 15, 1929 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis - chronic nephritis - ascites from Chronic Cardiac congestion. Coronary thrombosis.

(duration) 1 yrs. 0 mos. 15 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Buckford, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phila. Pa.	9/16/1929
20 UNDERTAKER Adam Sandstein	ADDRESS 1110-20 W. Mt Royal

IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—1-12-23—M&T—500 Bks.

E 49270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 49270

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1846 Mocheny St. 14-28 WARD)

2-FULL NAME Charles Fallon

(a) RESIDENCE No. 1846 McHenry ST., WARD 24.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Nov 15/28

7 AGE Years — Months 10 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — — —

(b) General nature of industry, business, or establishment in which employed (or employer) — — —

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Wm Fallon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Elsie Eckert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Barbara Hohman
(Address) 1846 Mocheny St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/14 .19 29. to 9/14 .19 29.
that I last saw h[illegible] alive on 9/14 .19 29.
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH* was as follows:

Acute ileo-colitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) Benjamin Weber, M. D.
, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Sept 16 1929

20 UNDERTAKER Mc-Kim Sr & Funk — ADDRESS 2512 Walbrook Ave

SEP 18 1929 HAMILTON JONES M.D.

TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

E 49271

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 Dolphin St. 11-24 WARD)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Coulter Woods Jr.

(a) RESIDENCE No. 1208 John St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? 22 yrs. 4 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Apl-24-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	22	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teacher.
(b) General nature of industry, business, or establishment in which employed (or employer) Teaching
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore. Maryland.

PARENTS

10 NAME OF FATHER Alex. C. Woods

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Burrows

13 BIRTHPLACE OF MOTHER (city or town) Williamsport (State or country) Penna

14 Informant Alex. C. Woods - (Father) (Address) 1208 John St. City

15 Filed ..., 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:* Suicide
Gun Shot Wound of Chest.
Survivor (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. ds.

(Signed) Geo. C. Gladden M. D.
(Coroner)
169 E. Biddle, 1929 (Address) 74-376 Bmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 0 yrs., 0 mos., ½ hour ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?
305 Dolphin St

Former or usual residence 1208 John St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery DATE OF BURIAL Sept 17 1929.

20 UNDERTAKER Stewart & Co. ADDRESS 1084 W Mont

Physician is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49272

CERTIFICATE OF DEATH

162 E 49272

1-PLACE OF DEATH West Balto Gen'l Hospt. 6-9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE. (No. ..... ST., ... WARD)

2-FULL NAME Baby Boy Lore

(a) RESIDENCE No. West Balto Gnl. Hosp ST., 1800 E Balto st WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-7-29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) W. B. G. Hospt Balto City Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ray Kinel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant N. Lore

(Address) 1800 E Balto st

15 Filed SEP 16 1929 HAMILTON JONES, M. D. Registrar

BY .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1929

17

I HEREBY CERTIFY, That I attended deceased from 9-7 1929 to 9-14 1929

that I last saw him alive on 9-14 1929

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Asphyxia Fatida.

8 (duration) yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Bilateral Hare Lip + Cleft Palate (duration) yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) S. A. Alessi M. D.

Sept. 15 1929 (Address) West. Balto. Genl. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL Sept 16, 1929

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto st

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

E 49273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49273

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecelia Berkley

(a) RESIDENCE NO. 2211 E. Pratt ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. H. Berkley

6 DATE OF BIRTH (month, day, and year) Jan 29, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	44	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Mary Rogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 13, 1924, to Sept 14, 1929, that I last saw h er alive on Sept 14, 1929 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension arteriosclerosis-
Cerebral hemorrhage
Chronic nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Hedwig Kreuz, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 9/17 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

18 SE 49274

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital. St., 18-29 Ward)

2-FULL NAME Thomas S. Mullen.

(a) RESIDENCE NO. 874 W. Lombard St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 18, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machine Hand
(b) General nature of industry, business, or establishment in which employed (or employer) Bed spring Mfg.
(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Mullen.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Annapolis, Md.

12 MAIDEN NAME OF MOTHER Susan Sands.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Annapolis, Md.

14 Informant Charles L. Mullen. (brother)
(Address) 2528 Robb St.

15 Filed SEP 16 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 18, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Compound fracture of the skull.
Accidental fall through a bridge.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fort Ave. Bridge.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquest

(Signed) Otto M Heimland, M. D.

9/14 1929 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 9/16 1929

20 UNDERTAKER Wm. Cook — ADDRESS 1217 E. Pratt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 49275

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N. Castle ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Hubbard

(a) RESIDENCE NO. 604 N Castle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary A Hubbard

6 DATE OF BIRTH (month, day, and year) Aug. 11. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Stevens & Co

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Jeremiah Hubbard

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Hyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Mary Hubbard
(Address) 604 N. Castle St.

15 Filed ..... 19 .....

SEP 16 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 19 29 to Sept 13 19 29

that I last saw h... alive on Sept 11 19 29

and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Hubbard M. D.

(Address) 604 N Castle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	9/16 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Simms

E 49276 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

E 49276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 929 Boyd St. (ST.) 18-29 (WARD)

2-FULL NAME Helen Virginia Simms,

(a) RESIDENCE-No. 929 Boyd St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred \ yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 22, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, \ hrs. or \ min.
	—	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Amos E. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fairfield, Md.

12 MAIDEN NAME OF MOTHER Francis Sommers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Amos E. Simms,
(Address) 929 Boyd St

15 Filed ..... 19 ..... Registrar

EP 16 1929 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 10. 1929. to Sept 14. 1929.

that I last saw h[illegible] alive on Sept. 14. 1929;

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia.

(duration) \ yrs \ mos 4 ds.

CONTRIBUTORY (Secondary) none

(duration) \ yrs \ mos. \ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam Etc.

(Signed) J. Thos. Bratton, M. D.

9/15, 1929. (Address) 8887 N. Loudon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Elkridge Md

DATE OF BURIAL Sept 16th 1929

20 UNDERTAKER A. Jones

ADDRESS, N.S. Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49277 | 161-00 | E 49277

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 Laurens ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Meehan

(a) RESIDENCE NO. 240 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14, 29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Thos. J. Meehan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Eleanor Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Camden N. J.

14 Informant Thos. J. Meehan

(Address) 240 Laurens St.

15 Filed SEP 16 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Sept 14, 1929, that I last saw h[illegible] alive on Sept 14, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Premature (6 mos. gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) F. L. Pelaglucca, M. D.

, 19 (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/16, 1929
20 UNDERTAKER	ADDRESS
Henry U. Mears & Son	805 N. Calvert

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49278

CERTIFICATE OF DEATH

91-002 E 49278

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 913 N. Eden ST. 16-13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Shee

(a) RESIDENCE NO. 913 N. Eden ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. — mos. — ds. How long in U. S., If foreign birth, — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed or divorced WIFE of (or) HUSBAND of Joseph Shee

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Gaddle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Katie V. Chambers

(Address) 1529 N. Lombard St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from May 30th 19 29 to Sept 15th 19 29 that I last saw h[illegible] alive on Sept 14th 19 29 and that death occurred, on the date stated above, at 2 a. m. The CAUSE OF HEATH* was as follows:

a Tobacco Tabacosis

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Hilner M. D.

(Address) 1900 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept. 17 1929
20 UNDERTAKER	ADDRESS
Henry Hoech & Sons Inc	1301 E Eager St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 49279

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3419 Esther Place 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine E. Wendler

(a) RESIDENCE NO. 3419 Esther Place WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Wendler

6 DATE OF BIRTH (month, day, and year): Oct 27th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Paul Leimbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Mueller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs B C Rube

(Address): 4215 Stevenson Ave

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 13-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Sept 13, 1929, that I last saw h alive on Sept 13, 1929, and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Hypertension & arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) M S Mazar, M. D.

(Address) 2612 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — DATE OF BURIAL: Sept 16 1929

20 UNDERTAKER: John Ulrich — ADDRESS: 2008 Aliceanna

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49280 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49280

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 E Fayette ST. 6-9 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances H. J Rode

(a) RESIDENCE NO. 1929 E. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Rode

6 DATE OF BIRTH (month, day, and year) Dec 14-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Rode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Rode

(Address) 1926 E Fayette

15 Filed ..... 19.. at .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14-1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 29 to Sept 14, 19 29

that I last saw him alive on Sept 14, 19 29

and that death occurred, on the date stated above, at 12:00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rydauch M. D.

(Address) 801 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Sept 16 1929

20 UNDERTAKER John Uelrich

ADDRESS 2008 Aliceanna

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49281

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49281

CERTIFICATE OF DEATH

45

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1471 N Kenwood Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael J Schultheis

(a) RESIDENCE NO. 1471 N Kenwood Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline J Schultheis

6 DATE OF BIRTH (month, day, and year) Oct 2 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Lorenz Schultheis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Rupp

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Mrs Caroline J Schultheis

(Address) 1471 N Kenwood

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1928, 19..., to Sept 15 1929, 19...

that I last saw h... alive on Sept 14 1929

and that death occurred, on the date stated above, at 12 30 P.m.

The CAUSE OF DEATH* was as follows:

E. Hemorrhage

Cancer of Rectum (duration) 1 yrs. 11 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home & died.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) Dr Lewis W Taylor, M. D.

Sept 15, 1929 (Address) 1616 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Sept 18 1929
20 UNDERTAKER John Ulrich	ADDRESS 200 N Calvert

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49282 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49282

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital (ST. 16-2 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Lee Ball.

(a) RESIDENCE NO. 260 S. Highland Ave. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ✓ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Ball

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Lila Whittington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Woodstock Virginia

14 Informant Mr. John Ball
(Address) 260 S. Highland Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Sept 14, 1929.
that I last saw her alive on Sept 14, 1929.
and that death occurred, on the date stated above, at 9 36 P. m.
The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph Schaefer M. D.

9/14/1929 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Sept 16, 1929
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 49283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 J E 49283

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N. Durham ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate A. Guy Bauer

(a) RESIDENCE NO. 112 N. Durham ST. 6 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest L. Bauer

6 DATE OF BIRTH (month, day, and year) June 19th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Lusner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ernest L. Bauer

(Address) 112 N. Durham St.

Filed SEP 16 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 13th, 1929, to Sept 14th, 1929, that I last saw h[illegible] alive on Sept 14th, 1929 and that death occurred, on the date stated above, at 4:50 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emil Geiger, M. D.

Sept 16, 1929 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 17 1929
20 UNDERTAKER Lilly & Geier Inc	ADDRESS 703 S. Wolfe St

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-E 49284

CERTIFICATE OF DEATH

E 49284

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 27 W. CHASE St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LUCY BUTLER LANIER

(a) RESIDENCE NO. 27 W. CHASE St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 1 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) OCTOBER 14 1852

7 AGE 77 Years 11 Months 1 Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) BALTIMORE, Md.

(State or country)

PARENTS

10 NAME OF FATHER SEMUNT LANIER

11 BIRTHPLACE OF FATHER (City or town) NASHVILLE

(State or country) TENNESSEE.

12 MAIDEN NAME OF MOTHER MARY SMITH

13 BIRTHPLACE OF MOTHER (city or town) BURLINGTON

(State or country) VERMONT

14 Informant BERWICK BRUCE LANIER

(Address) 1035 PARK AVE. NEW YORK

15 Filed ..... 19 ..... Registrar

SEP 18 1929 THOMSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

SEPTEMBER 15 1929

17

I HEREBY CERTIFY, That I attended deceased from —, 19 23, to SEPT 15, 19 29.

that I last saw her alive on SEPT. 15, 19 29.

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

(duration) 8+ yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK, BALTO. Date of Burial: SEPT. 17 1929

20 UNDERTAKER: HENRY W. JENKINS & SONS CO. ADDRESS: CITY.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49285

E 49285

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2212 Lake Ave & WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis. B. Belz

(a) RESIDENCE NO. 2232 Lake Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 ~~Single, Married~~ Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Belz

6 DATE OF BIRTH (month, day, and year) Nov 14 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10	c	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Belz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Susie Belz

(Address) 2232 Lake Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Sept 14, 1929, that I last saw him alive on Sept 13, 1929, and that death occurred, on the date stated above, at 7 40 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis & Hepatitis &
Cardiac Insufficiency due to
Lymphatic
Leukaemia (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Gastritis & Hepatitis &
Flatulence (duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? At his Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) O O Carman, M. D.

9-14. 1929 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 17 29
20 UNDERTAKER	ADDRESS
Jos Soerdens Son	2078 E. Pr

Important. See instructions on back of certificates.

HAMILTON JONES, M.D.

Spec.—1-12-23—M&T—500 Blks.

Gregor Mayr

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49286

CERTIFICATE OF DEATH.

49 E 49286

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Generals (WARD)

2-FULL NAME Gregor Mayr

(a) RESIDENCE NO. 1803 E Lombard ST, WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced
HUSBAND of Mrs Pauline Mayr
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69	6	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Expressman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Mayr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Pauline Mayr
(Address) 1803 E Lombard St

15 Filed SEP 16 1929, 19 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-27-, 1929, to 9-14-, 1929,
that I last saw h[illegible] alive on 9-14, 1929
and that death occurred, on the date stated above, at 8 55 a m
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 5 ds

CONTRIBUTORY (Secondary) Carcinoma of Prostate

(duration) yrs 6 mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-9-29

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam

(Signed) J R Castagna, M. D.

, 19 (Address) W. Balto Gen. Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 18 1929

20 UNDERTAKER: M. W. E. Hyssel Inc — ADDRESS: 312 Cam St

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

49287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 E 49287

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 128 S. Wolfe St. WARD)

2-FULL NAME Kunigunda Wolf.

(a) RESIDENCE NO. 128 S. Wolfe St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced (wife) of John Wolf

6 DATE OF BIRTH (month, day, and year) April 26 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Litz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John Wolf 128 S. Wolfe St

15 Filed SEP 16 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to Sept. 13, 1929.

that I last saw her alive on Sept. 13, 1929.

and that death occurred, on the date stated above, at 10-5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Elephantiasis

Chronic Erisepilas

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Grace I Tengler M. D.

9/17, 1929 (Address) 700 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 17 1929
20 UNDERTAKER	ADDRESS
M. W. E. Duffy & Son	31 Lan 4

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49288 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49288

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 N. Washington ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry C. Henderson Jr.

(a) RESIDENCE NO. 937 N. Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Iona M. Henderson

6 DATE OF BIRTH (month, day, and year) Sept. 10-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer P. O. Department

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Harry C. Henderson Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Maggie V. Kugler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Harry C. Henderson Sr.

(Address) 937 N. Washington St

15 Filed ....., 19 ..... Registrar

SEP 16 1929 C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 19 29, to Sept 14, 19 29, that I last saw h.. alive on Sept 14, 19 29 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis Acute

Edema (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam B. Leuman M. D.

9/15, 19 29 (Address) 718 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 17 1929
20 UNDERTAKER	ADDRESS
George W. Gilden	1737 E. Eager St.

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Kasik

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49289

CERTIFICATE OF DEATH.

E 49289

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkes Ave S. 25-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frances Kasik

(a) RESIDENCE NO. Fullerton, Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. 7 ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Chas Kasik

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 1037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Chas Kasik

(Address) Todd Ave, Bay Side

15 Filed [illegible] No. [illegible] By C. HARRISON [illegible] Registrar

P 16109

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Sept 14, 1929,

that I last saw h[illegible] alive on Sept 14, 1929,

and that death occurred, on the date stated above, at 10:35 P m.

The CAUSE OF DEATH* was as follows:

Hypertension - cerebral accident

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Stasis Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Sept 17 1929

20 UNDERTAKER Hunt-Crandell Co ADDRESS 1906 Eutaw

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49290 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49290

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 E. Madison ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther Schaffer

(a) RESIDENCE NO. 1928 E. Madison ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Moses Schaffer

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 65 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Lena Levin

(Address): 1928 E. Baltimore St.

15 Filed SEP 16 1929, 19 C. HAMPSON [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 16-1929

17 I HEREBY CERTIFY, That I attended deceased from 7/15, 1929, to 9/16, 1929, that I last saw h[illegible] alive on 9/16, 1929 and that death occurred, on the date stated above, at 5 30 A.M.

The CAUSE OF DEATH* was as follows:

[redacted]

Acute Cardiac Dilatation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Chr. Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Zimberg, M. D.

9/16, 1929 (Address) 2328 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Friendship — DATE OF BURIAL: 9-16-1929

20 UNDERTAKER: Jack Levin 1439 — ADDRESS: E Balto St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49291

CERTIFICATE OF DEATH

111-002

E 49291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore General

CITY OF BALTIMORE: (No. 19-28 ST. WARD)

2-FULL NAME Mr. Alonzo Gildmore

(a) RESIDENCE No. 324 S. Stricker ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

(If not resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Myrtle Atkinson Gildmore

6 DATE OF BIRTH (month, day, and year): July 12, 1895

7 AGE: Years 34 Months 2 Days 1 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Portsmouth, Va.

PARENTS

10 NAME OF FATHER: John Gildmore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Elizabeth Riggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Hospital Records (Address)

15 Filed 1 6 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 13, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929 to Sept. 13 1929.

that I last saw him alive on Sept. 13, 1929

and that death occurred, on the date stated above, at 7:20 p.m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Paralytic Ileus & General Peritonitis

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/9/29.

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical - autopsy.

(Signed) J. T. Castagna, M. D.

(Address) West Balto. General

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept 16, 1929

20 UNDERTAKER: Harry N. Wiltke, 1531 W. Lombard St. — ADDRESS

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49292 — 44 — E 49292

1—PLACE OF DEATH Mercy Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. 6-10 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Kaminski

(a) RESIDENCE NO. 227 N Port ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: Years 46 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: At Home.

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: unk.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: unk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Stanley Kaminski
(Address) 227 N. Port St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Sept 14, 1929, that I last saw her alive on Sept 14, 1929 and that death occurred, on the date stated above, at 3.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes — Date of 8/14/29 9/6/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operature

(Signed) J Zeyko, M. D.

9/14, 1929 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. Dundalk — DATE OF BURIAL: Sept 17 1929

20 UNDERTAKER: F. W. Grazewski 1930 — ADDRESS: Eastern Ave

Important. See instructions on back of certificates. Property classified. Read statement of OCCUPATION very

SEP 17 1929 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49293

CERTIFICATE OF DEATH

100-001 V

E 49293

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3-5 ST., WARD)

2—FULL NAME Rome Monte Monck

(a) RESIDENCE NO. 1002 E. Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) May 22. 1929.

7 AGE	Years	Months 4	Days 17	If LESS than 1 day, ...hrs. or ....min.
		4.	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant, 4 mo. old.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City.

PARENTS

10 NAME OF FATHER Ralph Nelson Monck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Catherine Hagaman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Catherine Monck
(Address) 1002 E. Pratt St.

15 Filed ....., 19 ..... RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to Sept 14, 1929

that I last saw h.... alive on Sept 14, 1929

and that death occurred, on the date stated above, at 9 25 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1/2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Guyton, M. D.

9/17. 1929 (Address) 9 Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel.	Sept 19 1929.
20 UNDERTAKER	**ADDRESS**
Kendall & Heptasophs	300 S Colvin St.

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.-7-17-26—A Co.—200 Bks.

49294

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 49294

CERTIFICATE OF DEATH

1-PLACE OF DEATH Aged Womens Home — REGISTERED NO.

City of BALTIMORE: (No. 1404 W Lexington St. 4-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1404 W Lexington St Mrs Ceen R Montague

(a) RESIDENCE NO. Mrs Ceen R Montague Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1846

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	83	2	14 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER George A Clark

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Saundiff

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs M E Baker

(Address) 1404 W Lexington

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1929 to Sept 15, 1929

that I last saw h~~e~~r alive on Sept 15, 1929

and that death occurred, on the date stated above, at 12 N

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY

(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin Garrett M. D.

, 19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park	Sept 17 1929
20 UNDERTAKER George J Smith	ADDRESS 453 Hollins

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49295 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49295

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Davis

(a) RESIDENCE NO. Ellicott city, Md ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER James R. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va -

12 MAIDEN NAME OF MOTHER Maggie Dasher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Maggie Davis

(Address) Ellicott City, Md

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept 13, 1929, that I last saw h alive on Sept 13, 1929 and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Diphtheria

(duration) 0 yrs 0 mos 18 ds.

CONTRIBUTORY (Secondary) Gastro - Enteritis (over

Pyelitis (duration) 0 yrs. 0 mos. 5 ds.

18 Where was disease contracted if not at place of death? Ellicott City, Md

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis Clinical findings

(Signed) Addison Craft Isley, M. D.

9.15 19 29 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Lutheran Cem	Sept 16 19 29
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-12-23—M&T—500 Blks.

E 49296

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49296

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 418 E. Clement (St.) W-33 (Ward) 105

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Bouldin

(a) RESIDENCE NO. 418 E. Clement ST., W4 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Johnson

6 DATE OF BIRTH (month, day, and year) — — 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) D. D. Grocers. 418 E. Clement St.

15 Filed SEP 19 1929 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1929, to Sept. 14, 1929, that I last saw h in alive on Sept. 13. 1929 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) Philip B. Fowler, M. D.

(Address) 1432 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL 9/17 1929

20 UNDERTAKER J. J. Talbert Sons ADDRESS 1318 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 188-103

E 49297

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial St., 33rd Ward)

2-FULL NAME Howard L. Hamilton

(a) RESIDENCE NO. Hayden Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Mar-1-1909

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	20	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General naturo of industry, business, or establishment in which employed (or employer) Agriculture
(c) Name of employer do

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Sam. J. Hamilton

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER M. Birdie Collier

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant S. O. Hamilton
(Address) 1333 E. Lehigh

15 Filed ... 19... C. HAMPSON JONES, M.D. Registrar

By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-15 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull — due to car running off road into run ditch

accident (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Cedarcroft Road

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. Frame M. D.

9/15 1929 (Address) 2939 W. Eldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid	9/16 1929
20 UNDERTAKER	ADDRESS
Geiger & Farley	Fulton & Fayette

C 1 6 1929

Pat ...

IMPORTANT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 49298

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 806 E 20th St. ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie Keating Shea

(a) RESIDENCE NO. 806 E 20th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John F Shea

6 DATE OF BIRTH (month, day, and year) 11-29-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Thomas Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hannah Hannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Shea.

(Address) 806 E 20th St

15 Filed SEP 16 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1929, to Sept 15, 1929, that I last saw h alive on Sept 14, 1929 and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Worley Long, M. D.

Sept 15 1929 (Address) 729 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Texas Md — DATE OF BURIAL Sept 17 1929

20 UNDERTAKER Geary NO Weidefeld — ADDRESS 20 E 22nd

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49299

CERTIFICATE OF DEATH.

161 001 E 49299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp. ST. 19-27 WARD)

2-FULL NAME Baby Boy Cole

(a) RESIDENCE No. Franklin Sq. Hosp. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. 1 hr. 55 min How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/12/29

7 AGE	Years	Months	Days	If LESS than 1 day, 1 hrs 55 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 00

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Cole

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Claudia Vogel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant
(Address) UNIVERSITY OF MARYLAND

15 SEP 16 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/12 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Sept 12, 1929, that I last saw h alive on Sept 12, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3 1929 (Address) 16 Randolph

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49300

CERTIFICATE OF DEATH

90 E 49300

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Adams

(a) RESIDENCE NO. 224 S. Fremont ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed SEP 6 1929, 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/14/29

17 I HEREBY CERTIFY, That I attended deceased from 2/14, 1922, to 9/14, 1929, that I last saw h.. alive on 9/14, 1929 and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

Senility

Varicose ulcer right leg

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

9/15, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Harford Rd	Sept 17th 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul st

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49301

CERTIFICATE OF DEATH.

24-29 E 49301

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1812 Rayner ST. 16-22 (WARD)

2-FULL NAME William D. McLeitch

(a) RESIDENCE No. 1812 Rayner ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B Leitch

6 DATE OF BIRTH (month, day, and year) 11-3-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	73	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk of

(b) General nature of industry, business, or establishment in which employed (or employer) General Provisions

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER George E Leitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Matilda Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Anna B Leitch

(Address) 1812 Rayner

15 Filed SEP 16 1929, 19.. C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Sept 15, 1929, that I last saw him alive on Sept 14, 1929, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G E Buxton, M. D.

9/16, 1929 (Address) 301 East Cross.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	9-17 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

INFORMANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49302

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ E 49302

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1021-N Mount ST. 16-22 WARD)

2—FULL NAME Elizabeth nee Gray Hepburn

(a) RESIDENCE NO. (Usual place of abode) 1621-N Mount ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced (or) WIFE of Charles Hepburn

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md

PARENTS

10 NAME OF FATHER Thos Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dut Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emma Frazier

(Address) 1621 N Mount St

15 Filed SEP 6 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-29

17

I HEREBY CERTIFY, That I attended deceased from 9-11-, 1929, to 9-13, 1929, that I last saw h[illegible] alive on 9-12-, 1929 and that death occurred, on the date stated above, at 11:20 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. L. Jackson, M. D.

9/15, 1929 (Address) 600 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley — DATE OF BURIAL 9-17-1929

20 UNDERTAKER Samuel Easton — ADDRESS 916 Dulaney

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49303

CERTIFICATE OF DEATH

90 E 49303

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 N. Milton Ave S. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thresa Hammer

(a) RESIDENCE NO. 210 N. Milton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Hammer

6 DATE OF BIRTH (month, day, and year) July 6 - 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Seltan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Kalbus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Hammer

(Address) 210 N. Milton Ave

15 Filed ....., 19.....

C. HAMPSON JONES, M. D.
Registrar

SEP 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1929, to Sept 15, 1929, that I last saw h[er] alive on Sept 15, 1929 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis & Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Joseph E. Johnson, M. D.

(Address) 3201 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Sept 18 1929

20 UNDERTAKER Bus C. Millerstrom ADDRESS 2334 Jefferson

important. See instructions on back of certificates.

Important. See instructions on back of certificates. Very carefully classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49304

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33 d & Calvert Lbg ST. 17-51 WARD)

REGISTERED NO. E 49304

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elijah Fillmore

(a) RESIDENCE NO. 323 N. Lorraine Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Wilhelmina Fillmore

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman Tel. Co.

(b) General nature of industry, business, or establishment in which employed (or employer) C & P Tel. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Fillmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Smythe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records.

(Address)

15 Filed ....., 19 .... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept 15, 1929

that I last saw h alive on Sept 15, 1929

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

unknown (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Francis W. Bluck, M. D.

9/15, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savage Md	Sept 19 29
20 UNDERTAKER	ADDRESS
Chesnut Hanson	2605 Eutaw Pl

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49305
1—PLACE OF DEATH

CERTIFICATE OF DEATH

31 ✓

E 49305
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1433 Park Av ST. 14-20 WARD)

2—FULL NAME Rosina Bigham

(a) RESIDENCE NO. 1433 Park Av. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. 2 mos. 8 ds. How long in U. S., if foreign birth? 85 yrs. 2 mos. 8 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Lindsay Bigham

6 DATE OF BIRTH (month, day, and year): July-9-1844

7 AGE — Years: 85 — Months: 2 — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Louis Passano

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Mary Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Delaware

14 Informant: Mrs Rosina Bigham (daughter)

(Address) 1433 Park Av.

15 Filed ....., 19 .....

C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1929, to Sept 16, 1929, that I last saw h alive on Sept 16 1929 and that death occurred, on the date stated above, at 5.12 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (R. Upper Lobe)
Succeeding Stomach Upset

(duration) 5 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pt

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) E. N. Harris, M. D.

. 19 (Address) 5535 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Sept 18 1929
20 UNDERTAKER	ADDRESS
Stewart & Mercer Co	Balto Md.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49306

CERTIFICATE OF DEATH

185

REGISTERED NO. E 49306

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Edgewood Sanitarium 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME M. Isabelle J. Silbery

(a) RESIDENCE NO. 502 Rose Hill Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 1 mos 29 ds. How long in U. S., if foreign birth 83 yrs. 1 mos 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): July 17 1846

7 AGE — Years: 83 | Months: 1 | Days: 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Francis L. Silbery

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown Germany

12 MAIDEN NAME OF MOTHER: Sarah C. Abbes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Germany

14 Informant: Mr. Chas. W. Silbery (Bro.)

(Address) 502 Rosehill Terrace

15 Filed ..... 19 .....

HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25 1929 to Sept. 16 1929.

that I last saw h alive on Sept 16 1929

and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Dislocated Hip, Fractured Femur + Colles Fracture

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Guy R. Booth, M. D.

19 (Address) 3957 Greenmount Ave Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmanuel Cemetery — DATE OF BURIAL: 9/19/1929

20 UNDERTAKER: Stewart Mowen Co — ADDRESS: Balto Md

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49307

CERTIFICATE OF DEATH

113 ✓ E 49307

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2016 E. North Ave ST., 17 WARD)

2—FULL NAME Myrtle Kline

(a) RESIDENCE NO. 2016 E. North Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 12/3/1928

7 AGE: Years —; Months 9; Days 12; If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Child

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: None Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md

12 MAIDEN NAME OF MOTHER: Thelma Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Thelma Kline

(Address): 2016 E. North Ave

15 Filed SEP 7 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 11 1929 to September 15 1929 that I last saw her alive on September 15 1929 and that death occureed, on the date stated above, at 1230 A m.

The CAUSE OF DEATH* was as follows:

Enteritis colitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Evolution

(Signed) Albert Casualty M. D.

9/16 1929 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natuee of Injury, and (2) whether Aecidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: 9/17/29

20 UNDERTAKER: George J Kuth Sons

ADDRESS: 1235 North Ave

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Blks.

E 49308

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 49308

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ~~[illegible]~~ ST. 15-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esaw Lee

(a) RESIDENCE NO. 1336 W. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Lee

6 DATE OF BIRTH (month, day and year) Unknown 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Esaw Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Julia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records

(Address) Baltimore City Hospitals

15 Filed SEP 17 1929 HAMPSON JONES, M. D. Registrar

By [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1929, to Sept 4, 1929, that I last saw him alive on Sept. 4, 1929, and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) Many yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Exam. Lab.

(Signed) L. M. Lumpkin, M. D.

, 19 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Sept 17 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Bressman St

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—1-12-23—M&T—500 Bks.

Mary R. Flood

E 49309 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 49309

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1555 n. Carey St. 15-21 WARD)

2-FULL NAME Mary R. Flood

(a) RESIDENCE NO. 1555 n. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christopher Flood

6 DATE OF BIRTH (month, day, and year) 4-14-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	55	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co. Maryland

PARENTS

10 NAME OF FATHER Ralph Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co. Md

14 Informant (Name) Venus R. Flood (Mrs) (Address) 1555 n. Carey St

15 Filed SEP 17 1929 19 C. HARRISON JONES Registrar

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14-1929

17 I HEREBY CERTIFY, That I attended deceased from 8-20, 1929, to 9-14, 1929, that I last saw h[illegible] alive on 9-14, 1929, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Vascular Disease

Personal Knowledge 2 months

History (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George C. Page M. D.

, 19 (Address) 516 n. Mont[illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 17 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelly	1303 Pennsylvania Ave

Spec.—2-29-28—L. F. S.—500 Blks.

Parrott

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49310

CERTIFICATE OF DEATH

3 1 ✓

E 49310

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 16-22 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alverta Parrott

(a) RESIDENCE NO. 1227 Parrish st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Parrott

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Viney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Shervin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed SEP 7 1929 H. Feed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1929 to Sept. 15, 1929

that I last saw her alive on Sept. 15, 1929

and that death occurred, on the date stated above, at 2.00 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) [illegible] M. D.

9-16, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 18 1929
20 UNDERTAKER	ADDRESS
Jam. H. Oliver Son	400 Mosher

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very [illegible] properly classified. [illegible] may be [illegible] cause

Spec.—2-29-28—L. F. S.—500 Blks.

E 49311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

×90 E 49311

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 Gibbons Ave ST. 27-44 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Colgan Sullivan

(a) RESIDENCE NO. 2601 Gibbons Ave ST., WARD New York.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick T. Sullivan

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Francis Colgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nellie Colgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Irel and

14 Informant Nellie Lacy

(Address) 2601 Gibbons Ave

15 Filed SEP 17 1929 W. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16, 1929

17 I HEREBY CERTIFY That I attended deceased from Aug. 25. 1929 to Sept 16. 1929 that I last saw her alive on Sept 15 1929 and that death occurred, on the date stated above, at 5.55 p m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) Sev. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual signs

(Signed) Mary F. Coughlan M. D.

9-16. 1929 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 9/18/1929.

20 UNDERTAKER Ritt Woodward 9+ ADDRESS Fremont Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49312

CERTIFICATE OF DEATH

44 E 49312

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 808 E. Eager Street ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sabina Killalea Burke

(a) RESIDENCE NO. 808 E. Eager Street ST., WARD
(Usual place of abode) (If non-resident give rity or town and State)

Length of residence in rity or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Burke

6 DATE OF BIRTH (month, day, and year) April 6, 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	8 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (rity or town) (State or rountry) Baltimore

PARENTS

10 NAME OF FATHER Thos. Killalea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or rountry) Ireland

14

Informant Miss Salie Burke

(Address) 808 E. Eager Street

15

Filed SEP 17 1929 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15, 1929.

17

I HEREBY CERTIFY That I attended deceased from April 16 1929 to Sept 15 1929

that I last saw her alive on Sept 14. 1929

and that death ocrurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 4 yrs
Gastric Carcinoma.

(duration) 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrarted if not at place of death? Unknown.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual ones.

(Signed) Mary F Vaughan. M. D.

9-16. 1929 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters	Sept. 18, 29.

20 UNDERTAKER Bula Wiedefeld ADDRESS 914 Gruman Ave

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

Peterson

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

CERTIFICATE OF DEATH

E 49313

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. E 49313

CITY OF BALTIMORE: (No. ——— ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Peterson

(a) RESIDENCE NO. 1214 N. Dallas ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer ?

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Va.

PARENTS

10 NAME OF FATHER Moses Peterson

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER Betty ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed SEP 7 1929, 19 [illegible] Registrar

C. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14-29

17 I HEREBY CERTIFY, That I attended deceased from 7-4, 1929, to 9-14, 1929.

that I last saw him alive on 9-14, 1929

and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency;

Arteriosclerosis (duration) over 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & P.E.

(Signed) Marvin M. McLean, M. D.

9-14, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Sept 17th 1929
20 UNDERTAKER	ADDRESS
Mrs. P. V. Elliott	1127 Ashland Ave

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-12-29—M&T—500 Blks.

E 49314 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49314

CERTIFICATE OF DEATH.

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. No. West Balt. Gen'l Hosp. ST. (WARD)

2-FULL NAME Max Sokolosky

(a) RESIDENCE No. 1418 E. Fairmount Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hinda Sokolsky

6 DATE OF BIRTH (month, day, and year): Sept 11 1929

7 AGE: Years 81 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Leib Sokolsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dunkon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Harry Sokolsky

(Address) 1418 E Fairmount Ave

Filed SEP 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept 17, 29, that I last saw him alive on Sept 17, 29, and that death occurred, on the date stated above, at 2.50 P.M.

The CAUSE OF DEATH was as follows:

Bronchopneumonia (Terminal).

CONTRIBUTORY (Secondary) (duration) yrs. mos. 4 ds. Fractured Humerus,

(duration) yrs. mos. 9 ds. Senility

Where was disease contracted if not at place of death? at home

Did operation precede death? No Date of 9/14/29

Was there an autopsy? No.

What test confirmed diagnosis? X-ray & Clinical

(Signed) J. V. Castagna M. D.

(Address) W. Balto. Gen. Hosp.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehren Rosedale — DATE OF BURIAL: 9/17 1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St.

THIS CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49315 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 49315

CERTIFICATE OF DEATH

161-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 240 Laurens ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Meehan

(a) RESIDENCE NO. 240 Laurens ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-14-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Joseph Meehan

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md
(State or country)

12 MAIDEN NAME OF MOTHER Eleanor Margaret Reed

13 BIRTHPLACE OF MOTHER (city or town) Camden N J
(State or country)

14 Informant Thos J Meehan

(Address) 240 Laurens St

Filed SEP 17 1929 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-16-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Sept 16, 1929, that I last saw her alive on Sept 16, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Premature (6 mos. Gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis D Ladagliace M. D.

, 19 (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/17 1929
20 UNDERTAKER	ADDRESS
E. W. Mears & Son	705 N. Eutaw St

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Dec.—1402J—M&T—1500 Bks.

E 49316

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49316

CERTIFICATE OF DEATH.

× 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Har Sinai Hospital ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Duffy

(a) RESIDENCE NO. Deal's Island MD ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred -- yrs. -- mos. 25 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Duffy

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	46	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Deal's Island Maryland

PARENTS

10 NAME OF FATHER Samuel C. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Indiana F. Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Deal's Island Maryland

14 Informant Mrs. Beulah Mosteller

(Address) Deal's Island, Md.

SEP 17 1929 C. H. [illegible] JONES, M. D.

Registrar

Via B. C. & A. Steamboat Co. Escort Mrs. Beulah Mosteller

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21 .1929. to Sept. 16 .1929.

that I last saw her alive on Sept. 16 .1929.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) (duration) Paresis about 1/2 yrs. mos. ds.; Syphilis (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? From husband, 1908

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) B J Cohen, M. D.

(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deal's Island, Md.

DATE OF BURIAL 9/17 1929

20 UNDERTAKER Henry H. Mears & Son

ADDRESS 805 N. Calvert

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49317 29048

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 ✓ E 49317

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2028 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph White

(a) RESIDENCE NO. 504 S. Payson St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-2-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Bd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frederic White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Groves

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929, to Sept 16, 1929, that I last saw him alive on Sept 16, 1929 and that death occurred, on the date stated above, at 2 50 A m.

The CAUSE OF DEATH* was as follows

Acute Intestinal Intussusception

Paralysis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W Brickford M. D.

9/7. 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Cemetery Harford Co.	Sept 18 1929
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Archie Nelson

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49318

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 415 N. Bond St St. 6-9 Ward)

2-FULL NAME Archie Nelson

(a) RESIDENCE NO. 415 N. Bond St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	COL	Single

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16/1912

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	17	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Iowa

PARENTS

10 NAME OF FATHER Archie Nelson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A.A. co., Md.

12 MAIDEN NAME OF MOTHER Cora Jefferson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Iowa

14 Informant Cora Nelson
(Address) 415 N. Bond St

15 Filed SEP 17 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 17/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) about 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & exam.

(Signed) [illegible] M. D.
9/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	sept 22 1929
20 UNDERTAKER	ADDRESS
Edward Bryan	1631 orleans st

31 ✓

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 49319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49319

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 W. Preston ST. 1-24 WARD)

2-FULL NAME Nathaniel Walker —

(a) RESIDENCE NO. 304 W Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mammie Walker

6 DATE OF BIRTH (month, day, and year) April 18 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer — yr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Has not worked for over 1 yr

9 BIRTHPLACE (city or town) (State or country) Maryland —

PARENTS

10 NAME OF FATHER John Walker —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland —

12 MAIDEN NAME OF MOTHER Delia Crumbler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland —

14 Informant Mary Woodard Cousin

(Address) Annapolis

15 Filed G. HAMPSON JONES, M. D. (Registrar)

by Asst

P 1 11929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 10th — 1929 to Sept 15th 1929.

that I last saw him alive on Sept 14th 1929

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

About — (duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Brights Disease and Dropsy — (duration) about yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bauer, M. D.

, 19 (Address) 937 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cem. DATE OF BURIAL Sept 18 1929

UNDERTAKER Eyerly and Ramsey ADDRESS 38 N Bond

Samuel Ramsey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49320

CERTIFICATE OF DEATH

38

E 49320

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Cole

(a) RESIDENCE NO. 690 West Mulberry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) N.C.

PARENTS

10 NAME OF FATHER Philip Cole

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) N.C.

12 MAIDEN NAME OF MOTHER Alice ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) N.C.

14 Informant Friends of

(Address) BALTIMORE CITY HOSPITALS

15 Filed ....., 19 .... Registrar

C. HAMPSON JONES, M. D.

SEP 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8-29

17 I HEREBY CERTIFY, That I attended deceased from 8-26, 1929, to 9-8, 1929, that I last saw him alive on 9-8, 1929 and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

1. Transverse Myelitis, Syphilitic

(duration) yrs. mos. 21 ds. ?

CONTRIBUTORY (Secondary) C.V.D. Syphilis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Hist. C.E. Lab. X-ray W.R.

(Signed) Warwick H. McLean, M. D.

9-8, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL Sept 17 1929

20 UNDERTAKER [redacted] Commissioner Health.

ADDRESS

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49321

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 8-17 WARD)

REGISTERED NO. 16-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Tyson

(a) RESIDENCE No. 1814 E. Washington St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1929

7 AGE Years Months Days If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...0...

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Paul Tyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant E. G. Douglas

(Address) Johns Hopkins Hospital

15 Filed SEP 17 1929 C. HAMPSON JONES, M. D. Registrar

Per 2946

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12 1929 to Sept. 15 1929

that I last saw he alive on Sept. 15 1929

and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) E. G. Douglas M. D.

(Address) Johns Hopkins Hospital 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Dept. of Health.

SEP 17 1929

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should make entries in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49322

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49322

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE. No. Johns Hopkins Hospital. ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Blanks

(a) RESIDENCE NO. 1401 Somerset ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
			1 1/2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country)

12 MAIDEN NAME OF MOTHER Emma Blanks

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant R. G. Douglas

(Address) Johns Hopkins Hospital

15 Dec 1 1929 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13 1929

17

I HEREBY CERTIFY, That I attended deceased from 9-12 .19 29. to 9-13 .19 29.

that I last saw her alive on 9-13 .19 29

and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) R. G. Douglas M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19....

19 UNDERTAKER ....

ADDRESS ....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

P 1 1929

Spec.—2-29-28—L. F. S.—500 Bks.

Quinton Long

E 49323

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49323

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1014 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Quinton Long

(a) RESIDENCE NO. 112 E. Monument ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, Oil

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? N. C.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER Adeline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed SEP 17 1929, C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-13-29

17 I HEREBY CERTIFY, That I attended deceased from 7-29, 1929, to 9-13, 1929

that I last saw him alive on 9-13, 1929

and that death occurred, on the date stated above, at 8⁰⁰ A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Nephritis, chronic

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist PE

(Signed) Marvin M. McLean, M. D.

9-13, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
UNIVERSITY OF MARYLAND	
20 UNDERTAKER	ADDRESS
D. Commissioner Health.	SEP 17 1929

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49324

CERTIFICATE OF DEATH

161-001

E 49324

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2704 Hunter ST. 27-43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Foltus Appleby

(a) RESIDENCE NO. 2704 Hunter ST.. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 9-15-29

7 AGE: Years 6 mos Months Days If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foltus

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md,

PARENTS

10 NAME OF FATHER: John Appleby

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Mary Hartley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: John Appleby

(Address): 2704 Hunter St

15 Filed 7 1929 19 CHAMPION JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-16-29

17

I HEREBY CERTIFY, That I attended deceased from 9-15-29, 19..., to 9-15-29 19..., that I last saw h alive on 9-15-29 and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Obstruction of Bowel

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) J. W. Foltus M.D.

9-16-29, 19 (Address) 2704 Hunter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL Sept 1 19 29

20 UNDERTAKER

ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E-29036 E-49325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002 E 49325

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank W. Bevin

(a) RESIDENCE NO. 1929 E Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	[illegible]

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-12-70

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse Orderly

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn

PARENTS

10 NAME OF FATHER Wm H. Bevin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Eliz H. Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Sept 14, 1929,

that I last saw him alive on Sept 14, 1929

and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

- Generalized Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of 9-13-29

Was there an autopsy? No

What test confirmed diagnosis? Exploration

(Signed) C D Bruce, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U.S. Nat Cem

DATE OF BURIAL 9/18 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Balto

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E Town

+1 E 49326

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3729 Belle Ave ST. 15-6 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leanna Fuller

(a) RESIDENCE NO. 3729 Belle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificate. Exact statement of OCCUPATION necessary

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis D Fuller

6 DATE OF BIRTH (month, day, and year): July 16. 1842

7 AGE — Years: 87 | Months: 2 | Days: 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Howard Co Md

PARENTS

10 NAME OF FATHER: Joseph Isaacs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Louisa Stubbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Roland Cook

(Address) 3729 Belle Ave

15 Filed ....., 19 ..... Registrar

HARPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 16. 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1928, to Sept 16, 1929, that I last saw h alive on Sept 16, 1929 and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast, with metastasis to whole glandular structure.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(durstion) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. F. Lemmon, M. D.

9/17, 1929 (Address) 350 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Mount — DATE OF BURIAL: 9/18 1929

20 UNDERTAKER: H H Cook — ADDRESS: 1217 E Balto

Spec.—1-12-23—MAT—800 Nbs.

(Lathe) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49327

CERTIFICATE OF DEATH.

25-12 29

E 49327

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2205 Tanglay ST. WARD

2-FULL NAME Walter Lathe

(a) RESIDENCE NO. 2205 Tanglay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Lathe

6 DATE OF BIRTH (month, day, and year) July 17 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	29 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sand dass engineer

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer Bait enamel & Nobelty co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas B Lathe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah E. Jeppo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Fred Johnston

(Address) 244 S Monroe.

15 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept 15, 1929, that I last saw him alive on Sept 12, 1929, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Calculus Ureter Stone

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Edema of Lungs

(Signed) Raymond S Adams, M. D.

(Address) Lakeland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Sept 18 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St paul st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49328

100-001

E 49328

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 818 Shutter St., 7-13 Ward)

2-FULL NAME Alton Price

(a) RESIDENCE NO. 818 Shutter St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	C.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Winfield Price

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Kent Co. Va

12 MAIDEN NAME OF MOTHER Goldie E. Travers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant
(Address) Winfield Price 81 Eastutter st.

15 Filed SEPT 18 1929 Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 10/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

(duration) yrs. mos. 2? da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J S Hoover, M. D.

9/10-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	Sept 11 1929
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 425 Ashland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49329

CERTIFICATE OF DEATH.

X 100 E 49329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Howard

(a) RESIDENCE NO. 766 W Lanvale ST., WARD 17.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of ~~or] WIFE of~~ Mary E. Howard

6 DATE OF BIRTH (month, day, and year) July 14, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60?	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte N.C.

PARENTS

10 NAME OF FATHER Ben Howard.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address) Son. 766 W. Lanvale St

15 Filed SEP 18 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/9, 1929, to 9/17, 1929, that I last saw h[illegible] alive on 9/17/29, 19, and that death occurred, on the date stated above, at 5.55 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Primary)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) George McDonald M. D.

, 19 (Address) Provident Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 9/19/29

UNDERTAKER Mrs. Leo A. Holland — ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49330

CERTIFICATE OF DEATH

REGISTERED 49330

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Bon. Hosp. St. 17-16 Ward)

2-FULL NAME Thomas Dorsey

(a) RESIDENCE NO. 632 Perkins St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) 1890 39 yrs

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Geo. Dorsey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Warren

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Sadie Taylor
(Address) 632 Perkins Ave

15 Filed ..., 19... Per ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wounded

(duration) ... yrs. ... mos. 1 da.

CONTRIBUTORY (Secondary) Convulsions

(duration) ... yrs. ... mos. 1 da.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J. C. Slater M. D.

... 19 (Address) 143 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 9/18/1929

20 UNDERTAKER Mrs. Ida H. Holland — ADDRESS 646 Druid Hill Ave

SEP 9 1930

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49331

CERTIFICATE OF DEATH.

31 V E 49331

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 Washington Blvd. (ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ipolus Scukda

(a) RESIDENCE No. 525 Washington Blvd. St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) NO. 1884

7 AGE 45 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NO.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Ipolus Scukda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Anne Paskauckas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Sopie Varnavskas

(Address) 525 Washington Blvd.

15 Filed SEP 18 1929 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 24 1929 to Sept. 16 1929, that I last saw him alive on Sept. 15 1929, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2m yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings X-ray

(Signed) A. Brukner, M. D.

9/17 1929 (Address) 37 D. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept. 19. 1929

20 UNDERTAKER: John Grebliuckas — ADDRESS: 1425 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49332 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 McElderry St. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie L. Brooks

(a) RESIDENCE NO. 2204 McElderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lokas Brooks

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rhoda Mason

(Address) 1819 Division St

15 Filed SEP 18 1929 C. HAMPSON JOHNS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 16 1929

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Sep. 16, 1929, that I last saw h alive on Sep. 16, 1929 and that death occurred, on the date stated above, at 12.07 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs ? mos da

CONTRIBUTORY ? (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Sheally M. D

Sept. 17, 1929 (Address) 1230 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Antrim Evergreen	9/19 1929
20 UNDERTAKER	ADDRESS
Paul F. Dennis	578 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49333 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 49333

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 407 N. Schroeder St. (WARD) 18-D

2-FULL NAME Hosea J. Palmer.

(a) RESIDENCE NO. 407 N. Schroeder St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy Palmer

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Shipyard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Carolina

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Stephen Williams

(Address): 407 N. Schroeder St.

15 Filed SEP 18 1929 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/16/29.

17 I HEREBY CERTIFY, That I attended deceased from Aug 15th 1929. to 9/16/29. 1929.

that I last saw him alive on 9/16/29. 1929.

and that death occurred, on the date stated above, at 3:35 P.M.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Organic Heart Dis.

(duration) yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Clinical

(Signed) H. Lee Thos. M. D.

19 29 (Address) 927 Mont. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: N. W. Baltimore

DATE OF BURIAL: 9/19/1929

20 UNDERTAKER: Samuel T. Beasley & Wm. Biddle

ADDRESS

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state whether disease was Acute or Chronic. Contributory or Secondary causes should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49334

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49334

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto city Hosp. ST. 17-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha E. Stewart

(a) RESIDENCE NO. 806 Fraser ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Stewart

6 DATE OF BIRTH (month, day, and year) May 14, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Clara Combs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record

(Address) C. HAMPSON JONES M.D.

15 Filed SEP 18 1929 By DRK

*Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16/29

17

I HEREBY CERTIFY, That I attended deceased from 9/10, 1929, to 9/16, 1929

that I last saw her alive on 9/16, 1929

and that death occurred, on the date stated above, at 1:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. U. Lumpkin, M. D.

9/17 1929 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 9/19/1929

20 UNDERTAKER Samuel Beasley

ADDRESS 578 N Biddle St

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49335

E 49335

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 19-27 Ward)

2-FULL NAME Lottie Smith

(a) RESIDENCE NO. 1412 W. Mulberry St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Eudmond .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Eudmond

12 MAIDEN NAME OF MOTHER Caroline Bailey

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) St Marys Co Md

14 Informant Lottie Barnes
(Address) 1412 W Mulberry

15 Filed SEP 18 1929, 19..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edgar Zeller M. D.

9/17. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9/16 1929
20 UNDERTAKER	ADDRESS
Saml D Hemsley	575 N Bond St

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49336

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49336

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto. General ST. [illegible] WARD) REGISTERED NO. 25455

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Elsa B. Manchey

(a) RESIDENCE NO. 3209 Rogers Ave ST., WARD Farm # 7
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin L. Manchey

6 DATE OF BIRTH (month, day, and year) August 17, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
31 yrs.		1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Stenographer

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Leopold Bachman

11 BIRTHPLACE OF FATHER (city or town) German
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Fauerbach

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Elsa B. Manchey
(Address)

15 Filed SEP 18 1929, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16, 1929

17

I HEREBY CERTIFY, That I attended deceased from 9-10, 1929 to 9-16, 1929

that I last saw her alive on 9-16, 1929

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Perforated appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction & [illegible] Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 9-10-29

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Edward A Liebinger, M. D.

, 19 (Address) 1213 Leger St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL 9/19/ 1929.

20 UNDERTAKER David Sondheim

ADDRESS Mt. W. mt. Royal Ave

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

E 49337 HEALTH DEPARTMENT—CITY OF BALTIMORE 46 E 49337

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Marlborough Apts. 1 B. ST 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Hamburger Likes

(a) RESIDENCE NO. Marlborough Apts. 1 B. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert H. Likes

6 DATE OF BIRTH (month, day, and year) Jany. 9th. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Iver Hamburger

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Coblens

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mr. Albert Likes

(Address) Marlborough Apts. 1 B. Lifetime

15 Filed SEP 18 1929 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17th. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Sept 17, 1929, that I last saw her alive on Sept 17, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Leitz, M. D.

9-18, 1929 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
(Cem.) Shalom Cem.	Sept. 19, 1929

20 UNDERTAKER Harris Sondheim

ADDRESS 1122 W. Mt. Royal Ave

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec. 1-10-21—M&T—1500 Blks.

E 49338

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49338

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital (STREET) (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allyn Foster Reinicker

(a) RESIDENCE NO. 3403 University Place ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, ✓ hrs. ✓ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harvey E Reinicker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Lyn Ingram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Harvey E. Reinicker

(Address) 3403 University Place.

15 Filed SEP 18 1920 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929. to Sept 17, 1929.

that I last saw h/m alive on Sept 17, 1929,

and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Rudolph G. Shook M. D.

9/17, 1929 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery.	Sept. 18, 1929.

20 UNDERTAKER Albert Bertram H. Gore ADDRESS 1723 N. Fayette Ave

Mar

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49339

CERTIFICATE OF DEATH

113 E 49339

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 S Calhoun St. 14-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. Henderson

(a) RESIDENCE NO. 416 S Calhoun ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 13 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7th 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	13 11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Christian F. Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Emily J. Loughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. John W. Henderson.
(Address) 416 S. Calhoun St.

15 Filed OCT 6 1928, 19 HAMPSON JONES—M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18, 1928

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1928, to Sept. 7, 1928, that I last saw h in alive on Sept. 17, 1928 and that death occurred, on the date stated above, at 2.20 A m.,

The CAUSE OF DEATH* was as follows:

Acute Ileo-colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings -

(Signed) Anthony V. Bodkins, M. D.

(Address) 37 D. Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Sept 19, 1928
20 UNDERTAKER	ADDRESS
John F. Cowan & Son	90 Holliday St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49340

CERTIFICATE OF DEATH

31 E 49340

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Owen J. Sweeney

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Sweeney

6 DATE OF BIRTH (month, day, and year) Aug. 3 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown Ireland

PARENTS

10 NAME OF FATHER John Sweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Ireland

12 MAIDEN NAME OF MOTHER Mary McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Ireland

14 Informant Mt Hope Retreat

(Address) Mt Hope Retreat

15 Filed OCT 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1926, to Sept 17, 1929, that I last saw h[illegible] alive on Sept 17, 1929 and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Toxoid Psychosis

Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Depressive Psychosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Sept 20 1929
20 UNDERTAKER	ADDRESS
John J Cowan & Son	90 Hollins St

Important. See instructions on back of certificates.

Spec.—12-23-21—E.S.R.S.—400 Blks.

E 49341

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49341

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Baby Boy Stevens

(a) Residence No. 1814 Wilhelm St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 9-14-29

7-AGE. ....yrs. ....mos. 3 ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS

10-NAME OF FATHER. Carlos Stevens

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Sophia Travis Lucas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland.

14- (Informant) Carlos Stevens

(Address) 1814 Wilhelm St

15-

Filed ..... 192.. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-17-29

17- I HEREBY CERTIFY, That I attended deceased from 9-14- 1929 to 9-17 1929

that I last saw him alive on 9-17 1929

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

PREMATURITY (34 wks)
Twin #2

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No (Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis H. Krieg Jr. M. D.

9/18 1929 (Address) Univ. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Sept 18 1929
20-UNDERTAKER.	ADDRESS.
Henry Heitzke	1531 W Lombard St

100#

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49342 ✓ E 49342

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq Hosp (St.) 21-29 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine B. Peterson

(a) RESIDENCE NO. 1120 Cleveland St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar M. Peterson

6 DATE OF BIRTH (month, day, and year) Jun 13. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	8	34	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John J. Schomburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edgar M. Peterson

(Address) 1120 Cleveland St.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 29.

17 I HEREBY CERTIFY, That I attended deceased from 8/8/29, 19.., to 9/17, 1929, that I last saw h[illegible] alive on 9/17, 19 29 and that death occurred, on the date stated above, at 3.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with uraemia.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. 1 mos. 9 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test - blood chem

(Signed) Arthur Cattenni, M. D.

9/17, 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 19 1929
20 UNDERTAKER	ADDRESS
Wm & Mus J. W. Teufel & Son	501 W. Fayette

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 49343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ E 49343

1-PLACE OF DEATH

City of BALTIMORE: (No. 2752 Maryland Ave. Ward 12-51) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Lee

(a) RESIDENCE NO. 2752 Maryland Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Lee

6 DATE OF BIRTH (month, day, and year): Feb. 22 - 1845

7 AGE: Years 84 | Months 6 | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town):

(State or country) Baltimore Md.

10 NAME OF FATHER: Francis Sinclair

11 BIRTHPLACE OF FATHER (city or town):

(State or country) France

12 MAIDEN NAME OF MOTHER: Victoria Hirsch

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

14 Informant: Mrs. Teresa Lee

(Address) 2752 Maryland ave

15 Filed....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 17th 1929

17

I HEREBY CERTIFY, That I attended deceased from Sep. 1, 1929, to Sep. 17, 1929, that I last saw her alive on Sep. 17, 1929, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age 17

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E. L. Bouchelle, M. D.

9-17-1929 (Address) 2124 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial 9/20 1929

20 UNDERTAKER: Chas. R. Waudtson ADDRESS 1800 Royal Ave

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49344

CERTIFICATE OF DEATH

101-001 E 49344

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1644 Thomas ave ST. 15-66 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Lewis

(a) RESIDENCE NO. 1644 Thomas ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Lewis

6 DATE OF BIRTH (month, day, and year) Aug 4 - 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cheaneer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Lemeul Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Balto St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/17/29.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1929, to Sept. 17, 1929, that I last saw h[illegible] alive on Sept. 17, 1929 and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Right lower lobe

(duration) — yrs. — mos. 3 da.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) — yrs. — mos. 7 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W B Lewis M. D.

9/18/1929 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	9/19/1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

Be CERTAIN to print terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49345

66 E 49345

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 642 W. Barre St. 07-30 Ward)

2-FULL NAME Charles Berry

(a) RESIDENCE NO. 642 W. Barre St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Hattie Berry

6 DATE OF BIRTH (month, day, and year) Oct. 5 - 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30.	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Long shoreman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S. C.

PARENTS

10 NAME OF FATHER Henry Berry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Mary Berry

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S.C.

14 Informant Mrs. Hattie Berry
(Address) 642 W. Barre St

15 Filed ....., 19.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept. 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Coroner, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Geltr M. D.

9/17, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Sept. 19 1929

20 UNDERTAKER J. Lewis Thompson — ADDRESS 2325 Madison Av

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49346 47 ✓ E 49346

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Josephs Hospital WARD) 1-24

2—FULL NAME Carrie Holland

(a) RESIDENCE NO. 906 Brevard St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Holland

6 DATE OF BIRTH (month, day, and year) March 17 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	56	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henson Darsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriet Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Daniel Holland

(Address) 906 Brevard St.

15 Filed ..... 19 ..... Registrar

SEP 8 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18-29

17 I HEREBY CERTIFY, That I attended deceased from 9-17, 1929, to 9-18, 1929, that I last saw h[illegible] alive on 9-18, 1929, and that death occurred, on the date stated above, at 7:50 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

CONTRIBUTORY (Secondary) Acute Auricular Congestion (duration) yrs. mos. 1/2 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Pathologist

(Signed) W M Brindley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Sept 20 1929
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49347

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49347

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hedwig Young

(a) RESIDENCE NO. 1334 Forest Rd ST., Sparrows Point WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. 2 ds. How long in U. S., if foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Young

6 DATE OF BIRTH (month, day, and year) April 20/1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Heinrich Bals

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Therese Wunderlich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

1 8 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept-10, 1929, to Sept-17, 1929.

that I last saw her alive on Sept-17, 1929

and that death occurred, on the date stated above, at 5 35 A m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mitral Stenosis & Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) Hedwig Koenig, M. D.

9/17, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Sept 19/29
20 UNDERTAKER Philip Stevens	ADDRESS 2016 Orleans St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49348

CERTIFICATE OF DEATH

90 E 49348

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1238 E. Chas ST. 10-14 WARD)

2—FULL NAME Annie Siegman

(a) RESIDENCE NO. 1238 E. Chase ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Sept 10/1851

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm H. Siegman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Eyth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm Siegman

(Address) 1527 N. Durham St.

15 Filed SEP 18 1929, 19 HAMPSON, John M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16/29

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to Sept 16th, 1929, that I last saw her alive on Sept 16th, 1929 and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Insufficiency Mitral
Coronary Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leo Selver M. D.

(Address) 4900 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Sept 19 29
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Eden St

important. See instructions on back of certificates.

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Blks.

E 49349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

13 E 49349

1—PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Orleans ST., 27 WARD)

REGISTERED NO. 27-41

2—FULL NAME Harriet Sack

(a) RESIDENCE NO. 2711 Ailsa Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John P. Sack

6 DATE OF BIRTH (month, day, and year): March 28th 1874

7 AGE — Years: 55 | Months: 5 | Days: 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 37 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: John P. Sack (Address): 2711 Ailsa Ave.

15 Filed 9 8 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/16/29

17

I HEREBY CERTIFY, That I attended deceased from 9-5-29, 19 to 9-16-29, 19

that I last saw h alive on 9-16-29, 19

and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Psycho Hydro Infection

Left Kidney

(duration) 0 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Pyelitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9 16 29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W B Hundley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Sept. 19 29

20 UNDERTAKER: Frederick Lorsch Home — ADDRESS: Fullerton

Spec.—2-20-28—L. F. S.—500 Blks.

Emrine

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49350

CERTIFICATE OF DEATH

+ 31 E 49350

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 26-37 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Emrine

(a) RESIDENCE NO. Catonsville Manor, Md. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer 0-57

(b) General natore of indostry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Emrine

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Emrine

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 19 29, to Sept. 17, 19 29, that I last saw h. in alive on Sept. 17, 19 29 and that death occurred, on the date stated above, at 7.15 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

9-17, 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 9/20 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 Lt Pratt St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very ... properly classified.

SEP 18 1929 HAMPSON JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49351

CERTIFICATE OF DEATH

38 E 49351

1—PLACE OF DEATH Balto City Hospt. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto Md ST., 3-5 WARD)

2—FULL NAME Emma Kelly

(a) RESIDENCE NO. 1064 Granby St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Kelly

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md.

15 Filed 9 1929 C. WIMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-15-29

17 I HEREBY CERTIFY, That I attended deceased from 8-15, 1929 to 9-15, 1929

that I last saw her alive on 9-15, 1929

and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Termed Bronchopneumonia

General Paralysis of Insane

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Suicide Injection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathological & Clinical findings

(Signed) Thos. F. Donnelly M. D.

9/16 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	9/19 1929
20 UNDERTAKER	ADDRESS
J. M. Cook	1217 E. Fond St

Important. See instructions on back of certificates. Every question must be answered.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49352

CERTIFICATE OF DEATH

161-001 E 49352

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 n. Dallas ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Fagan

(a) RESIDENCE NO. 106 n. Dallas ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 18. 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establiishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Fagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Emma Maddox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Marshin Md.

14

Informant Emma Fagan

(Address) 106 n. Dallas St.

15

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18-29

17

I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1929, to Sept. 18, 1929, that I last saw h alive on Sept 18, 1929, and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

Nasal Hemorrhage (1 hour)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Rh Gram

(Signed) W. L. Berry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Sept 18 1929

20 UNDERTAKER — ADDRESS

Johns Hopkins Hospital

Commissioner Health

important. See instructions on back of certificates.

Per. Wm. H. Welsh

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49353

CERTIFICATE OF DEATH.

167-001

E 49353

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital 43-59 WARD)

2-FULL NAME Baby Girl Bernstein

(a) RESIDENCE NO. 939 Brooks Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day... hrs. 20 min.
	✓	✓		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harry Bernstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ida Grunblatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Ida Bernstein. (Address) 939 Brooks Lane.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929, to Sept 13, 1929.

that I last saw h Cl alive on Sept 13, 1929.

and that death occurred, on the date stated above, at 10-15 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity. (See over)

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) none

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no ✓

What test confirmed diagnosis? Clinical.

(Signed) Rudolph Schaefer M. D.

19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carnegie Lab. | DATE OF BURIAL 19

20 UNDERTAKER | ADDRESS

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 13 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-092

E 49354

E 49354

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. President Hosp. St. 11-24 Ward)

2-FULL NAME Irving A. Hall.

(a) RESIDENCE NO. 112 S Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE — Years: 62 — Months: — Days: — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Coal dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Wm H Hall

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Caroline Brown

13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Isabella Hall
(Address): 523 N Calhoun St

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 17th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) Sept 17th 1929 H. Hedrich, M. D.
(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Sept 19 1929

20 UNDERTAKER: John H Trader — ADDRESS 1027 Hund Hill

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49355

CERTIFICATE OF DEATH

90 E 49355

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 14-20 ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Harris

(a) RESIDENCE NO. 2000 Druid Hill Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown Jan 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed SEP 13 1929 19 Reg. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1929 to September 17, 1929

that I last saw him alive on September 17, 1929

and that death occurred, on the date stated above, at 5:40 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Gangrene, L.L. foot, arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist.

(Signed) Harris H. McLean M. D.

9/18, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge, Md.

DATE OF BURIAL 9/19/1929

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill

important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49356

CERTIFICATE OF DEATH

178 ✓ E 49356

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. West Balto Gen Hosp 70-70 Ward)

2-FULL NAME Lottie Johnson

(a) RESIDENCE NO. 3303 Edmondson Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem'l	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant C. B. Gore
(Address) 3303 Edmondson Ave

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 17th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Nephritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? 3303 Edmondson Ave
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leech, M. D.
Sept 17th 29 (Address) Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Helena Cem	9-18 1929
20 UNDERTAKER Dennis Corkran	ADDRESS 916 Gay

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49357

CERTIFICATE OF DEATH

113 E 49357

1-PLACE OF DEATH

City of Baltimore: (No. 1146 Russell St. St. 21-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Azatta Neal.(O)

(a) RESIDENCE NO. 1146 Russell St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 14, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	11	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wilbur Waters.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 ~~MAIDEN~~ NAME OF MOTHER Mary Neal.(O)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md

14 Informant Mary Neal.(O) mother.
(Address) 1146 Russell St.

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 17, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquest

(Signed) Otto M. Leonhardt, M. D.

9/18, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cet	Sept 19 1929
20 UNDERTAKER	ADDRESS
A. M. Brown & Son	[illegible]

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49358

45 ✓

CERTIFICATE OF DEATH

REGISTERED NO. E 49358

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 435 East Gitting ST 74-33 WARD)

2—FULL NAME Thomas H Haagensen

(a) RESIDENCE NO. 435 East Gitting ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Wirland

6 DATE OF BIRTH (month, day, and year) April 16 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) woodwork

(c) Name of employer Robert Garrett

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Thomas Haagensen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Mrs Caroline Haagensen

(Address) 435 E Gitting St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 17, 1929

that I last saw him alive on Sept 17, 1929

and that death occurred, on the date stated above, at 10.15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) Don't Know

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

9.18, 1929 (Address) 107 Eastwest St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Garrett	Sept 19, 1929
20 UNDERTAKER Chas. L. Stern	ADDRESS 1307 E Fort Ave

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49359

CERTIFICATE OF DEATH

E 49359

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (St.) (Ward) 1612

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. George Westphal

(a) RESIDENCE No. 2717 W. Baltimore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Wickens

6 DATE OF BIRTH (month, day, and year) Dec 28 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	53	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Painter 063

(b) General nature of industry, business, or establishment in which employed (or employer) Paper

(c) Name of employer William F. Wilkins

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Westphal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Seitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Westphal

(Address) 2717 W Balto St

15 Filed SEP 19 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Sept. 17, 1929, that I last saw him alive on Sept. 17, 1929, and that death occurred, on the date stated above, at 11.15 a.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulo-nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical and Laboratory

(Signed) D. Kastagna, M. D.

, 19 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Sept 21 1929

20 UNDERTAKER Chas. L. Storm ADDRESS 1501 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49360

129 ✓

CERTIFICATE OF DEATH

E 49360

1—PLACE OF DEATH 140 N May Street

REGISTERED NO.

CITY OF BALTIMORE: (No. 59 ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Benjamin Robinson

(a) RESIDENCE NO. 140 N May ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Clara Robinson

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 56 | Months | Days | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Howard Co., Md

PARENTS

10 NAME OF FATHER: Benjamin Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Clara Robinson

(Address) 140 N May St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-16-29

17

I HEREBY CERTIFY, That I attended deceased from 9-3-, 1929, to 9-16, 1929, that I last saw h... alive on 9-15, 1929, and that death occurred, on the date stated above, at 3:25 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. S. Butler, M. D.

, 19 (Address) 425 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	9-19 1929
20 UNDERTAKER	ADDRESS
Byron Wright	1218 N Eden St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49361

CERTIFICATE OF DEATH

91-002 ✓

E 49361

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 20-65

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Deering

(a) RESIDENCE NO. 2613 Sloatfield Ave. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Deering

6 DATE OF BIRTH (month, day, and year) Feb. 13, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. of Stables

(b) General nature of industry, business, or establishment in which employed (or employer) 17

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Deering

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed ....., 19 .....
7-3-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 31, 19 29 to Sept. 17, 19 29

that I last saw h. im alive on September 17, 19 29

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pemphigus Vulgaris

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? History P.C. Lab.

(Signed) Marvin W. McClean, M. D.

9-18, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Cemetery - Dorsey, Md.	Sept. 20, 1929.
20 UNDERTAKER John J. Penny	ADDRESS 715 Light St.

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49362

CERTIFICATE OF DEATH

113 ✓ E 49362

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1911 Riggs Ave. ST 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Coyle Guilfoy, Jr.

(a) RESIDENCE NO. 1911 Riggs Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Jany. 4th. 1929.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Coyle Guilfoy

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Levi

13 BIRTHPLACE OF MOTHER (city or town) Lynchburg. (State or country) Va.

14 Informant Mrs. I. Philipson

(Address) 1911 Riggs Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from 9/17/29, 19 ..... to 9/19/29, 19 .....

that I last saw h[illegible] alive on 9/19/29, 19 .....

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Mucoid Colitis

(Signed) Walter C Bacon, M. D.

, 19 (Address) 100 East 20th. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	9/20/ 1929

20 UNDERTAKER David Sondheim

ADDRESS 118 20 W. Mt. Royal ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

O'Dea

E 49363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49363

1—PLACE OF DEATH St Joseph Hospital REGISTERED NO. 9-17

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. O'Dea

(a) RESIDENCE NO. Hyattsville Md ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 10 mos. ds. How long in U. S., If foreign birth 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced (or) WIFE of Thomas O'Dea

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. Coffey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Wm. Andrew C. Dillon

(Address) 1232 N. Caroline St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1929

17

I HEREBY CERTIFY, That I attended deceased from 9/3, 1929, to 9/18, 1929

that I last saw her alive on 9/18, 1929

and that death occurred, on the date stated above, at 7:15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/9/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. A. Turnage, M. D.

9/19, 1929 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept. 21 1929
20 UNDERTAKER	**ADDRESS**
Henry Koch Sons Inc.	130 E Eager St

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 49364

REGISTERED NO. E 49364

1-PLACE OF DEATH

City of BALTIMORE: (No. 2008 Mc Henry St St. W-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Pauline Schmidt.

(a) RESIDENCE NO. 2008 Mc Henry St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of: August Schmidt.

6 DATE OF BIRTH (month, day, and year): December 25-1855

7 AGE: Years 73 Months 8 Days 22 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Retired.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany.

PARENTS

10 NAME OF FATHER: Charles Walter.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany.

14 Informant: John Frank Schmidt.

(Address) 2008 McHenry St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept 16-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929 to Sept 16, 1929.

that I last saw h.. alive on Sept 16, 1929.

and that death occurred, on the date stated above, at 11:10 P.M.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

Hemiplegia

(duration) ....yrs. ....mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted ✓

If not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) Hellen Hemmeter M. D.

9/18. 1929 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — Date of Burial: Sept. 20 1929.

20 UNDERTAKER: Charles J. Schwab. — ADDRESS: 505 N. Monroe St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

-8-16-29—L. F. S.—100 Bks.

49365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 49365

REGISTERED NO.

1—PLACE OF DEATH Hebrew Aged Home

CITY OF BALTIMORE: (No. Belvedere Home Ave ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Tobije Stein

(a) RESIDENCE NO. 10 S. Edwin St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? 7 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Stein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant J. Lewis

(Address) 1429 E Baltimore St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-19-29

17 I HEREBY CERTIFY, That I attended deceased from July-15, 1929, to Sept-19-, 1929, that I last saw h.. alive on Sept-19-, 1929, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Myo-Cardial insufficiency

about one year

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) none

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

Sept-19 1929 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 9-9-29

20 UNDERTAKER per Lewis, 1429 E Baltimore St. — ADDRESS

R 9 1929 HAMPSON

Exactly as the terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

1—PLACE OF DEATH E 49366

REGISTERED NO. E 49366

CITY OF BALTIMORE: (No. 403 S. 4th Greene ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Salvatore Cascio

(a) RESIDENCE NO. 403 S. 4th Greene ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Grace

6 DATE OF BIRTH (month, day, and year) Feb 5-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Cascio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Sarah Cultotta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Sam. Cascio

(Address) 403 S. 4th Greene St

15 Filed ..... 19 ..... C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17-1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to Sept. 17, 1929

that I last saw him alive on Sept. 16, 1929

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April, 6, 1925

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) A. Tommasello, M. D.

19 (Address) 306 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 20 1929
20 UNDERTAKER	ADDRESS
Williams Cook	1217 St Paul St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49367

CERTIFICATE OF DEATH

16-002 V

E 49367

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST. 3 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Gramhill

(a) RESIDENCE NO. 727 S Regester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry Cramhill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elizabeth Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Elizabeth Cramhill

(Address) 727 S. Regester

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 19 29, to Sept 18, 19 29, that I last saw h.e alive on Sept 18, 19 29, and that death occurred, on the date stated above, at 10:35 P m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Trauma from Acid Ingestion (duration) yrs. mos. 1 day

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Bacteriological

(Signed) M Hundley, M. D.

, 19 (Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N.O. Ghurch	Sept 21 19 29
20 UNDERTAKER	ADDRESS
Wm Cahn	1217 St Paul

y crassified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 i

E 49368

E 49368

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hospital ST. 9-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gerdus Bartholow

(a) RESIDENCE NO. 861 Woodward ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Bartholow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah C. Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Record
(Address)

Filed ..... 19 ..... Registrar

SEP 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18/29

17 I HEREBY CERTIFY, That I attended deceased from 7/12, 1929, to 9/18, 1929,

that I last saw him alive on 9/18, 1929

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Inguinal adenitis right
sided Senility

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7/15/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin M. D.

9/19, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 20 1929
20 UNDERTAKER B. L. Harle	ADDRESS 1005 S. Paca St.

Instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 49369

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp. St., [illegible] Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Harding

(a) RESIDENCE NO. 1912 Hennman ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	C.	Single

5a If married, widowed, or divorced
HUSBAND nf
(or) WIFE nf

6 DATE OF BIRTH (month, day, and year) Sept 6 1919

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
10	0	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Harding

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country) Va

12 MAIDEN NAME OF MOTHER Caroline Laurence

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country) N. C.

14 Informant Wm. E. Harding
(Address) 1912 Hennman ave

15 Filed....., 19..... Registrar

KRB

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 10/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described abnve, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendix
General Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease cnntracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes at Hopkins

What test confirmed diagnosis?

(Signed) John Fow M. D.

9/19/29 (Address) 503 E. North ave

*State the Disease Causing Death, or in deaths frnm Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Sept 12 29
20 UNDERTAKER Thos. J. Elliott	ADDRESS 1725 Ashland

Spec.—1-10-21—M&T—1500 Bks.

E 49370 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49370

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital 10-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cyrus A Smith

(a) RESIDENCE NO. Fulton Ave & Franklin St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Smith

6 DATE OF BIRTH (month, day, and year) 9/18/1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Captain retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Geo. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Catherine Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Hospital Records

15 Filed 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-17, 1929, to 9-18, 1929, that I last saw him alive on 9-18, 1929 and that death occurred, on the date stated above, at 10:20 A.m.

The CAUSE OF DEATH* was as follows:

Fracture Femur Rt. arrested

(duration) yrs. mos 31 ds.

CONTRIBUTORY (Secondary) Cardio-Renal disease a Uremia (duration) 2 yrs. mos. ds.

Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Robert Wells, M. D.

(Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 20 1929
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stf. -7-1-26—A Co.—200 Bks.

E 49371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-201 V
74 E 49371

REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home

City of BALTIMORE: (No. 1404 W Lexington St. 4-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Esther

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 78 — Months — Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Martha E Baker

(Address) 1404 W Lexington

15 Filed SEP 19 1929, 19 ..... HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 19 29

17 I HEREBY CERTIFY, That I attended deceased from March 13, 19 27, to Sept 19, 19 29

that I last saw her alive on Sept. 10, 19 29

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Apoplexy

P. T. Rad Nov 8 stroke prior to Death (duration) 8 yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin B Jowett M. D.

. 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial Sept 20 1929

20 UNDERTAKER George J Smith

ADDRESS 153 L Holliday

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49372 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 49372

REGISTERED NO.

1—PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Orleans St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mildred Turner

(a) RESIDENCE NO. 737 W Mulberry St., 19 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20, 916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eastport, (State or country) Md

PARENTS

10 NAME OF FATHER Isaac Chambers

11 BIRTHPLACE OF FATHER (city or town) Annapolis (State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Turner

13 BIRTHPLACE OF MOTHER (city or town) West Cove (State or country) Md

14 Informant Virginia Turner
(Address) 737 W. Mulberry St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16/29

17 I HEREBY CERTIFY, That I attended deceased from 9-12-29, 19... to 9-16-29, 19...
that I last saw h.. alive on 9-16-29, 19...
and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonic Tuberculosis
Disease with Peritonitis

(duration) ... yrs. ... mos. 0 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-13-29.

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A B Hendrey, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 19, 19 29
20 UNDERTAKER Mrs Kate R Williams	ADDRESS 322 [illegible]

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 49373

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Eator Ave ST., 4-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Estelle Courtenay

(a) RESIDENCE NO. 610 Eator ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Austin V. Courtenay

6 DATE OF BIRTH (month, day, and year) Dec 20 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas H Sprankle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary V. McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Austin V. Courtenay

(Address) 610 Eator ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 1928, to Sept. 18 1929.

That I last saw her alive on Sept. 18 1929

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastasis to lungs.

(duration) 21 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

Pulmonary edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 15/28

Was there an autopsy? yes

What test confirmed diagnosis? Physical Examination

(Signed) John T. Owens M. D.

9/18 1929 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 20 1929
20 UNDERTAKER John O Mitchell and Son	ADDRESS 1900 Eutaw Place

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49374

CERTIFICATE OF DEATH

129 E 49374

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. St. 12-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J Dudley

(a) RESIDENCE NO. 4100 N. Charles St., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Dudley

6 DATE OF BIRTH (month, day, and year) Sept 8 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	61		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt - Relief dept

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R. R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Fred Dudley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carleton md

14 Informant Mrs Louise Dudley

(Address) 4100 N. Charles St

15 Filed ....., 19 .....

1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 19 29 to Sept. 19, 19 29

that I last saw him alive on Sept. 19, 19 29

and that death occurred, on the date stated above, at 4,15 P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio Vascular Renal disease

(duration) yrs. mos. 2 ds. ?

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory

(Signed) Luther C. Peter, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Sept 21 1929
20 UNDERTAKER	ADDRESS
John O Mitchell Sons	1900 Eutaw Place

Exactly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49375

CERTIFICATE OF DEATH

E 49375

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hosp St. 25-12 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos B. Flemming

(a) RESIDENCE NO. Ellicott City St., 8 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Flemming

6 DATE OF BIRTH (month, day, and year) Mar 25 - 1848

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	81	5	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Miller
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer none

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Jno Flemming

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Gosnell

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Margaret Flemming
(Address) Ellicott City Md.

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

1 9 1929 Nov

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fract Skull - Fract Humerus C.C.L.
Fract all L. Ribs & Concussion Brain
struck by automobile
& knocked down (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Ellicott City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Frame, M. D.

1929 (Address) 2789 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Chapel Cumb. Md.	9/21 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 49376

CERTIFICATE OF DEATH

167 E 49376

1-PLACE OF DEATH

City of Baltimore: (No. 1216 Ostend St. 21-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David B. Lockhart

(a) RESIDENCE NO. 1216 Ostend St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1853.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	76	7	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Moses Lockhart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER
Annie E. Fury.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant Mrs. Florence Bray,
(Address) 852 W. Balto. St.,

15 Filed ..... 19.... C. HAMPSON JONES, M. D.
Registrar

OCT 19 1929 Bur

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

CO Poisoning. Illuminating gas.
Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

9/19 19 29 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept. 20 19 29
20 UNDERTAKER Joseph D. Cook	ADDRESS 1003 West Baltimore St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29— A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49377

1984

E 49377
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 533 Greenwillow St.; 17-24 Ward)

2-FULL NAME Marie Spriggs

(a) RESIDENCE NO. 533 Greenwillow St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
1903.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Seamstress.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jas Boone

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Tena Berrun.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Tena Ferguson
(Address) 642 W. Hoffman St.

SEP 20 1929

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Fractured Skull

(duration) yrs. Sudden

CONTRIBUTORY (Secondary) Struck with fist

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death 533 Greenwillow St.

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Regular

(Signed) H. Blanck M. D.
Sept 17 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Sept 20 1929

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Hanover

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49378

1-PLACE OF DEATH

E 49378

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Brady & Vera Aves. St. 25-76 Ward)

2-FULL NAME Miles Partlow.(C)

(a) RESIDENCE NO. 3314 Remley Ave. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) December 25 1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21	8	20	17

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Miles Partlow.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Emma Shoats.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant John Partlow.(C) brother.
(Address) 20 E. Church St.

15 Filed SEP 20 1929 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 14, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquest. (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pistol shot wound of the chest penetrating the Aorta.
Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & inquest.

(Signed) Otto M. Steinhardt, M. D.

9/18. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Sept 20 1929
20 UNDERTAKER	ADDRESS
R. L. Parham	1007 E. Monument

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49379

CERTIFICATE OF DEATH

E 49379

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3038 McElderry ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mark Carroll Fahey

(a) RESIDENCE NO. 3038 McElderry St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret G. Fahey.

6 DATE OF BIRTH (month, day, and year) June - 6 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	- 3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Ed. Fahey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann. Carroll.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Anna L. Hagen.

(Address) 3038 McElderry St.

Date 19 Registered. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18/29.

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to Sept. 18, 1929, that I last saw h alive on Sept. 17, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry B. Fahey, M. D.

9/9, 1929 (Address) 2502 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	9/21 1929
20 UNDERTAKER	ADDRESS
Fahey & Sons	318 Light

EP 20 1929

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49380 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 49380

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 644 N. Baltimore ST. H-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jasper F. Donovan

(a) RESIDENCE NO. 644 N. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER R. B. Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary B. Sugar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. R. E. Donovan

(Address) 163 E Randolph

15 Received [illegible] 19 [illegible] Registrar

P 2 0 1929

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/19/29

17 I HEREBY CERTIFY, That I attended deceased from 9/16/ 1929 to 9/19/ 1929

that I last saw h alive on 9/19/ 1929

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry H. Weinberger M. D.

9/19/29 (Address) 724 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisonburg Va.	9/20/ 1929
20 UNDERTAKER	ADDRESS
John F. Fahey & Sons	1318 Light

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Foster 928 N Charles St
X 46

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49381

E 49381

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 446 E - 22nd ST. 12-50 WARD)

2—FULL NAME Edith Kenyon

(a) RESIDENCE NO. 446 E - 22nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James M.

6 DATE OF BIRTH (month, day, and year) Jan 13 - 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48		8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer " "

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm H. Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Helen Dodson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant James M Kenyon

(Address) 446 E 22nd st

15 Filed SEP 20 1929 19 [illegible] JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1929, to Sept. 19, 1929, that I last saw h[illegible] alive on Sept 19, 1929 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus with metastasis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis, Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Heart & breath

(Signed) Herbert M. Foster, M. D.

, 19 (Address) 928 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen, Camden Cy	9/20 1929
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul ST

Please write plainly in permanent black ink, and in all cases where the answer to any question is unknown, state the fact, as all parts of this certificate are important. See instructions on back of certificates.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49382

CERTIFICATE OF DEATH.

10 E 49382

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 S. Eutaw St. 7-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Boone

(a) RESIDENCE NO. 502 S. Eutaw ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor Boone

6 DATE OF BIRTH (month, day, and year) Feb 3 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Boone

11 BIRTHPLACE OF FATHER (city or town) Calvert Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Butler

13 BIRTHPLACE OF MOTHER (city or town) Charles Co
(State or country) Charles Co Md

14 Informant Esther Boone
(Address) 1013 N. Eutaw

15 Filed SEP 20 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/5 1929 to 9/18 1929 that I last saw him alive on 9/18 1929 and that death occurred, on the date stated above, at 11 40 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Dan Grunbaum M. D.

9/18 1929 (Address) 1111 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvert Co. Md — DATE OF BURIAL Sept 22 1929

20 UNDERTAKER Wm H. Chase Son — ADDRESS 1400 Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 49383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-6 E 49383

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 E. Barney ST. 24 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma J. Krause

(a) RESIDENCE NO. 508 E Barney ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 6th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry P Krause

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wells

12 MAIDEN NAME OF MOTHER Christine Visser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wells.

14 Informant Henry P Krause

(Address) 508 E Barney st.

15 Filed SEP 20 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Sept 18, 1929, that I last saw h alive on Sept 18, 1929, and that death occurred, on the date stated above, at 9-45 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edward K. L. Campbell M. D.

Sept 18, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Sept 25th 1929
20 UNDERTAKER E Schloman Son	ADDRESS 1029 Hanover st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 ✓

E 49384

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3029 Windsor Ave ST. 15-61 WARD)

2—FULL NAME Mrs Josephine Clara Brady

(a) RESIDENCE NO. 3029 Windsor Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of R. S. Brady

6 DATE OF BIRTH (month, day, and year) Sept 15 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Mr Blimline

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Richard McClellan
(Address) 3029 Windsor ave

15 Filed ..... 19 .....
Registrar

FEB 20 1929 WILLIAM H. JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 29.

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 19 29, to Sept 18, 19 29, that I last saw h[illegible] alive on Sept 14, 19 29, and that death occurred, on the date stated above, at [illegible] m. The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

Sept 18, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	9-21 1929
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Sons Co.	Orchard & McCulloh

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49385
1—PLACE OF DEATH

CERTIFICATE OF DEATH

GVE 49385

CITY OF BALTIMORE: (No. 600 Brookwood Rd St. 28-65 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME FRANK NORMAN HILLIS SR

(a) RESIDENCE NO. 600 Brookwood St. Rd WARD
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Parker

6 DATE OF BIRTH (month, day, and year): March 8, 1883

7 AGE — Years: 46 | Months: 6 | Days: 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): General Practice
(c) Name of employer: Self

9 BIRTHPLACE (City or town) (State or country): British Guinia, B. Amer.

PARENTS

10 NAME OF FATHER: John D. Hillis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Clarice Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Laura Hillis
(Address): 600 Brookwood Rd

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar
Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Sept 19, 1929, that I last saw him alive on Sept 17, 1929, and that death occurred, on the date stated above, at 12.10 A m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam + Symptoms

(Signed) Dr. [illegible] M. D.

(Address) 705 Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Sept 21st 1929

20 UNDERTAKER: Leary & Hutchinson — ADDRESS: McTague & Orchard St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1129

REGISTERED NO. 28-65

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. J. Hartwell

(a) RESIDENCE NO. 5316 Wedley Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, ~~widowed~~ or divorced HUSBAND of (or) ~~WIFE of~~: Unknown

6 DATE OF BIRTH (month, day, and year): Sept 19 1872

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Funeral Director

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: Wm Cook

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Bart. Hartwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Joana Boland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Father Hartwell

(Address): St. Mary's Rectory Fells Pt. Md.

15 Filed SEP 20 1929, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 30, 1929, to September 19 1929, that I last saw him alive on Sept 19, 1929 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis and valvular heart disease

(duration) over 3 mo. yrs. mos. ds.

CONTRIBUTORY (Secondary): None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Henry C Cole, M. D.

9-19, 1929 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral bur

DATE OF BURIAL: Sept 22 1929

20 UNDERTAKER: Chas J Jenkins Sons Co

ADDRESS: Chas & Cold St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49387

228872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x 16-002

E 49387
REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2—FULL NAME George Heiner

(a) RESIDENCE NO. North Point Rd & Carroll Ave ST. WARD
(Usual place of abode) Colgate Md

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/18/29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7 6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ∅

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Heiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wisconsin

12 MAIDEN NAME OF MOTHER Catherine Lehmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Date received SEP 23 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17-29

17

I HEREBY CERTIFY, That I attended deceased from 9-8-, 1929, to 9-17-, 1929

that I last saw h.. alive on 9-17-, 1929

and that death occurred, on the date stated above, at 5 00 P. m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentary

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Colgate, Md

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) V. C. Goodwin, M. D.

9/18, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL Sept 20, 1929

20 UNDERTAKER Jno C. Miller & Son — ADDRESS 2554 Jefferson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49388

CERTIFICATE OF DEATH.

E 49388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 W. Churchill St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Brown

(a) RESIDENCE No. 9 W. Churchill St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs or mm

72 3 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not known

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 29 1929 to Sept. 18 1929

that I last saw h[illegible] alive on Sept. 18 1929

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs mos ds

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs mos 8 ds

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Bacteriology

(Signed) [illegible] M. D.

Sept. 19 1929 (Address) 326 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address) Mrs. Lillie Thompson 109 N. Fremont Ave.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 9/21 1929

20 UNDERTAKER Walter B. Spigg

ADDRESS 139 N Hanover St.

15 [illegible] Registrar

SEP 20 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

E 49389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49389

1-PLACE OF DEATH

City of BALTIMORE: (No. 800 Burgundy St. 21-31 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Henry Jacob

(a) Residence No. 800 Burgundy St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Marie Jacob

6-DATE OF BIRTH (month, day and year) April 12, 1861

7-AGE. 68 yrs. 5 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... proprietor of grocery store

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Henry Adam Jacob

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

11- (Informant) Mrs Carolina Ref

(Address) 800 Burgundy St.

15- ...HAMPSON JONES, M. D.

SEP 20 1929 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 17, 1929

17- I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1927 to Sept. 17, 1929

that I last saw h.m alive on Sept. 17, 1929

and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

cerebral arteriosclerosis

about 2 yrs

(Duration) ...yrs. ...mos. ...ds

CONTRIBUTORY (Secondary) hemiplegia

(Duration) ...yrs. ...mos. 9 ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual tests

(Signed) George A Kemp M. D

, 19 (Address) 3030 Edmondson ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	9/20/29 19....
20-UNDERTAKER.	ADDRESS
Geo Lintack Co	525 N Lyndhurst

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 49390

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49390

161-001

E 49390

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Rear 5410 W. Monument St., 4-27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown Male

(a) RESIDENCE NO. _____ St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 18 '29

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant A. W. Dial

(Address)

15 Filed SEP 20 1929 E. HAMPSON JONES, M. D.

By _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ (Coroner) M. D.

(Address) Coroner's Office

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital Date of Burial 19

20 UNDERTAKER

ADDRESS

Commissioner Health. SEP 19 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49391

CERTIFICATE OF DEATH.

74-001

E 49391

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 W Fairmont ST., 17 WARD)

2-FULL NAME Benjamin Foster

(a) RESIDENCE NO. 1520 W Fairmont ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Thelma Foster

6 DATE OF BIRTH (month, day, and year) 8-6-1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46 yrs	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore + Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greenwood

PARENTS

10 NAME OF FATHER Miles Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greenwood S. C.

12 MAIDEN NAME OF MOTHER Annie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greenwood S. C.

14 Informant Thelma Foster
(Address) 1520 W. Fairmont Ave

15 Filed SEP 20 1929, 19... C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Sept 18, 1929, that I last saw him alive on Sept 18, 1929 and that death occurred, on the date stated above, at 2:40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 3 hrs

CONTRIBUTORY (Secondary) Paralytic Stroke

(duration) ... yrs. ... mos. 7 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical Exam

(Signed) H. A. Walters M. D.

, 19 (Address) 1438 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL 9-20 1929

20 UNDERTAKER Charles G Boyer

ADDRESS 514 E Eutaw St

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Marie Liske

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49392

E 49392

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 Brice ST. 70-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Liske

(a) RESIDENCE NO. 517 Brice ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12, 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Julius Liske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eva Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Marie Liske 517 Brice St

Filed SEP 20 1929 C. HAMPSON JONES, M. D. Registrar

By E

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-12 1929 to Sept 19 1929

that I last saw her alive on Sept 19 1929 9:15 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Diarrhea & Inflammation

(Signed) Thos. H. Phillips M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 9/20 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 N. Paulst

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49393

CERTIFICATE OF DEATH

90 E 49393

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 252 S. Caton ST. 20-70 WARD)

2—FULL NAME Emma C. Porter

(a) RESIDENCE NO. 252 S. Caton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis C Porter

6 DATE OF BIRTH (month, day, and year) Nov. 1 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster
(State or country) Penn

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Margaret Gist
(Address) 252 S. Caton

15 Filed SEP 20 1929, 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Sept 18, 1929, that I last saw her alive on Sept 18, 1929 and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Contributed 3 days,
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Thos. A. Johnston M. D.

Sept. 19, 1929 (Address) 3610 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Cathedral	Sept 21 1929

20 UNDERTAKER Wm Cook Jr & Son-Paul ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 49394

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Jenkins Memorial Hospital (STREET) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw. Paul Clements

(a) RESIDENCE NO. 1907 Cedar Road ST., WARD Philadelphia, Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 5, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles County Maryland

PARENTS

10 NAME OF FATHER Francis H. Clements

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria L. Ware

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Rosa Clements

(Address) 1907 Cedar Road

15 [illegible] 20 1929 [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1929

17

I HEREBY CERTIFY, That I attended deceased from 7-27, 1929, to 9-19, 1929,

that I last saw him alive on 9-19, 1929

and that death occurred, on the date stated above, at 1 40 p m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Brewer M. D.

9/19, 1929 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Sept 21, 1929

20 UNDERTAKER Wm J Tucker & Sons

ADDRESS Norfolk Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 49395

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49395

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

City of BALTIMORE: (No. 3025 Frisby St. St., 9-46 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Francis Roberts

(a) Residence No. 3025 Frisby St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: wh.

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Amy Roberts.

6-DATE OF BIRTH (month, day and year): Aug. 3, 1853

7-AGE: 76 yrs. 1 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Carr Lowry Glass Foundry

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS:

10-NAME OF FATHER: Chas H. Roberts.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Mary E. Sevin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14-(Informant): Eliza H. Roberts

(Address): 3025 Frisby St.

15-[illegible]

SEP 20 1929

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Sept 20, 1929.

17- I HEREBY CERTIFY, That I attended deceased from April ? 1926 to Sept 20 1929.

that I last saw him alive on Sept. 19, 29 1929

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Edema of Lungs

(Duration) yrs. mos. 10 ds

CONTRIBUTORY (Secondary) Carcinamatosis

(Duration) 2 yrs. mos. ds

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? ? Date of

Was there an autopsy? ?

What test confirmed diagnosis? Usual signs

(Signed) Geo. L. Wells, M. D.

9/20, 1929 (Address) 4100 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Sept. 24, 1929

20-UNDERTAKER: Harry K. Waltjen & Co. — ADDRESS: 3110 W. Lombard St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49396 ✓ 90 E 49396

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2864 Hanford Rd ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie May Shipley

(a) RESIDENCE NO. 2864 Hanford Rd ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C. Shipley

6 DATE OF BIRTH (month, day, and year) January 24 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm H. Simpson

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Harrington

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Wm C. Shipley

(Address) 2864 Hanford Rd

15 Filed OCT 20 1929 19 C. HAMPSON JONES, M. D. Registrar Per BCR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19- 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929, to Sept 19, 1929, that I last saw h[illegible] alive on Sept 18, 1929 and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Hypertension 24 hrs.

Myocarditis 14 yrs.

Acute Dilation of Heart 20 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) J. Wm. H. Simpson M. D.

Sept 20 1929 (Address) 2878 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	9/21 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 E Pratt St

IMPORTANT. See instructions on back of certificates. Write DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION [illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

E 49397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

13 E 49397

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 Durham ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Donald William Conrad

(a) RESIDENCE NO. 1803 Durham ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/12 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 / 29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER William W Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louise Baumer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant William W Conrad

(Address) 1803 Durham st

15 Filed OCT 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 16 29 to Sept 19 29

that I last saw h alive on Sept 19 1929

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Acute Mia Colitis

(duration) yrs mos. da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

.19 (Address) 800 N Dug Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Conn	9/21 19 29
20 UNDERTAKER	**ADDRESS**
Wm Cook	1217 St Paul st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 002

E 49398 — CERTIFICATE OF DEATH — 91 E 49398

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Greenmount Ave. WARD) — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Manion

(a) RESIDENCE NO. 2313 Greenmount Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Manion

6 DATE OF BIRTH (month, day, and year) July 19 45

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Daley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Margaret Emrick.

(Address) 2313 Greenmount Ave.

15 SEP 20 1929 C. HAMPSON JONES, M. D. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 yrs. to Sept 19 1929, that I last saw her alive on Sept 18 1929, and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. L. Ingram, M. D.

19 (Address) 2439 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cemetery	Sept 21 1929
20 UNDERTAKER	ADDRESS
Wirdefeld	501 E. 22 St.

IMPORTANT. See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49399

CERTIFICATE OF DEATH

70 E 49399

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edwin Holden

(a) RESIDENCE NO. 1658 Gorsuch Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 30 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single —

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 20, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	30 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edwin Holden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Gertrude Pohlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Edwin Holden

(Address) 1658 Gorsuch Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929 to Sept 19, 1929 that I last saw him alive on Sept 19, 1929 and that death occurred, on the date stated above, at 10-35 p m.

The CAUSE OF DEATH* was as follows:

Simple Encephalitis

(duration) 0 yrs. 0 mos. 12 ds.

CONTRIBUTORY (Secondary) None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 1658 Gorsuch Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Irby, M. D.

9-20, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 23 1929
20 UNDERTAKER	ADDRESS
Stewart & Mowen Company	108 W North Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49400

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2503 Maryland ave 7-5 WARD)

2—FULL NAME Martha Louise Cottingham

(a) RESIDENCE NO. 2503 Maryland ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Cottingham

6 DATE OF BIRTH (month, day, and year) Aug 7th 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Natural Bridge Virginia

PARENTS

10 NAME OF FATHER John D Houston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Samuel Cottingham

(Address) 2503 Maryland Ave

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

SEP 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20-29

17 I HEREBY CERTIFY, That I attended deceased from June 5th, 1928, to Sept 20th, 1929, that I last saw her alive on Sept 19th, 1929 and that death occurred, on the date stated above, at 3:20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma, mammary gland

(duration) 1 yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Thos H Cullen, M. D.

19 (Address) 78 W 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Sept-23-1929
20 UNDERTAKER	ADDRESS
Stewart & Mowen Co	108 N. North Ave

If DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, give its NAME instead of street and number.

Fill in all items, if none, write none. Information must be complete and accurate as far as known. Do not abbreviate. Write plainly in ink. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 49401

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2912 St. Paul ST. 7-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha B. Emory

(a) RESIDENCE NO. 2912 St. Paul ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Emory.

6 DATE OF BIRTH (month, day, and year) Sept-30-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	68	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Georgetown
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Grimes

11 BIRTHPLACE OF FATHER (city or town) ? ?
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ann E. Clagett

13 BIRTHPLACE OF MOTHER (city or town) ? ?
(State or country) Maryland

14 Informant Mrs. Wm Clagett Emory

(Address) 2912 St Paul Street

15 Filed 2 01929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19th 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 19th, 1929, to Sept 19th, 1929.

that I last saw h alive on Sept 19th, 1929

and that death occurred, on the date stated above, at 9-30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage due to Chronic Nephritis and Hypertension

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? V

(Signed) Stephen Buck, M. D.

9/19, 19 (Address) 215 S Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Arridental, Suicidal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 21st 1929
20 UNDERTAKER	ADDRESS
Steuart & Mowen Company	138-10 North Ave.

P

Property classified. Exact statement of OCCUPATION necessary
important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49402

CERTIFICATE OF DEATH

1929 E 49402

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 4334 Falls Road ST. 27-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Hedges Sparklin

(a) RESIDENCE NO. 4334 Falls Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Sparklin

6 DATE OF BIRTH (month, day, and year): Feb-28-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Barton J. Sparklin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Ruth Ann Mott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs. Thomas B. Cowish

(Address) 4334 Falls Road.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

P 2 0 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 19 29, to Sept 19, 19 29, that I last saw him alive on Sept 19, 19 29, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) One yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Necropsy

(Signed) Herbert J. Stiellmann, M. D.

19 (Address) 6 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	9/23 1929
20 UNDERTAKER	ADDRESS
Stewart & Mowen Company	108 W. North Ave

Be DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 49403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-08 E 49403

1-PLACE OF DEATH

City of BALTIMORE: (No. 2410 Maryland Ave. St. 17-51 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Andrew Buckingham

(a) RESIDENCE NO. 1918 Eutaw Place St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Grace Laucks Buckingham

6 DATE OF BIRTH (month, day, and year) Mar-18-1855

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

9 BIRTHPLACE (city or town) York

(State or country) Penna

PARENTS

10 NAME OF FATHER John W. Buckingham

11 BIRTHPLACE OF FATHER (city or town) York

(State or country) Penna.

12 MAIDEN NAME OF MOTHER Elizabeth Reginley

13 BIRTHPLACE OF MOTHER (city or town) York

(State or country) Penna.

14 Informant Mrs. John Buckingham

(Address) 1918 Eutaw Place.

15 Filed 20 1929 C. HAMPSON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Mowbray M. D.

Coroner

9-20 1929 (Address) 632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cem. York, Penna Date of Burial Sept-2-1929

20 UNDERTAKER Stewart & Mowen Co. ADDRESS 108 W. North Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49404

CERTIFICATE OF DEATH

+ 100-001

E 49404

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emil Polecheh

(a) RESIDENCE NO. 2200 Madison ST., WARD East Lan Market Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

a If married, widowed, ur divorced HUSBAND of (or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) Dec 25 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
64	63	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer. do

(b) General nature of industry, business, or establishment in which employed (or employer) Farm work.

(c) Name of employer

9 BIRTHPLACE (city or town) Prague
(State or country) Austria

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Prague
(State or country) Austria

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Prague
(State or country) Austria.

14 Informant Daughter
(Address) 2200 Madison St.

15 Filed SEP 20 1929, 19 Registrar

P 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 /29

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Sept. 20, 1929, that I last saw h in alive on Sept. 20, 1929 and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma. Chronic Bronchitis. Emphysema arterio sclerosis general

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Broncho Pneumonia
(Secondary)
Pulmonary Edema (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes autopsy clinical symptoms

What test confirmed diagnosis? Physical & Examination

(Signed) H. Glenn Spicher, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
East Lan Market Md	Sept 22 29
20 UNDERTAKER H B Willoughby.	ADDRESS Harbock Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49405

CERTIFICATE OF DEATH

118-001 49405

E 49405

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel P Enfield

(a) RESIDENCE NO. Forest Hill md ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of mrs S.S. Enfield

6 DATE OF BIRTH (month, day, and year) Sept 3. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob. Enfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Nancy Hawkill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Dr S E Enfield

(Address) Cumberland md

15 Filed ... 19 C. HAMILTON JONES, M. D. Registrar

SEP 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21. 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Sept 21, 1929, that I last saw him alive on Sept 21, 1929 and that death occurred, on the date stated above, at 2:35 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Inguinal Hernia (Strangulated) (duration) 1 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Forest Hill

Did an operation precede death? Yes Date of Sept 12

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings.

(Signed) Jesse L. Yoder, M. D.

. 19 (Address) U. M. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Statesville Pa	Sept 23 1929
20 UNDERTAKER	ADDRESS
Dem & Fortney Bel Air Md	

Be sure to state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

49406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 182 E 49406

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Pier No. 5 Port Covington. St. 6-9 Ward)

2-FULL NAME Robert Burnett.(C)

(a) RESIDENCE NO. 108 N. Dallas St. St., Ward 9 C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	25	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Palmyra, N. C.
(State or country)

PARENTS

10 NAME OF FATHER Louis Erket.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 ~~MAIDEN~~ NAME OF MOTHER Julia Burnett.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant Julia Burnett.(C) mother.
(Address) Palmyra, N. C.

15 Filed ..... 192 H. Hessel JONES, M. D.
Registrar
Per

SEP 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 16, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a scow.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Feinnauld, M. D.

9/10. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Palmyra, N. C.	Sept 21 1929
20 UNDERTAKER Mrs. Kate R. Williams	ADDRESS 322 N Schroeder St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Hensen

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49407

CERTIFICATE OF DEATH

49 E 49407

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1242 Edythe St., 5-8 Ward)

2-FULL NAME Nathaniel Hensen

(a) RESIDENCE NO. 1242 Edythe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Maggie Hensen

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) a'to
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Nathaniel Hensen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Martha Hensen (sister)
(Address) 1242 Edythe

15 Filed SEP 21 1929 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 17/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Carcinoma of rt. lung & lymph nodes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of Sep 5/29

Was there an autopsy? Yes at Hopkins Hospital

What test confirmed diagnosis?

(Signed) J S H Cotton, M. D.

9-20-29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	9-21 1929
20 UNDERTAKER	ADDRESS
Byron & Wright	1218 McCulloh

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 49408 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49408

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 Gold St. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm S. Ross

(a) RESIDENCE NO. 719 Gold ST, WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1928

7 AGE — Years | Months: 11 | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER William L. Ross.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Saxton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William L. Ross

(Address) 719 Gold St

15 Filed 9 21 1929 J. HAMPSON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/21 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/14, 1929, to 9/21, 1929.

that I last saw h[illegible] alive on 9/20, 1929

and that death occurred, on the date stated above, at 1:15 A m

The CAUSE OF DEATH* was as follows:

Whooping Cough +

Bronchopneumonia 7 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Slutts, M. D.

9/21, 1929 (Address) 2139 O. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Sept 24 1929

20 UNDERTAKER: Virginia A. Brooks — ADDRESS: 1160 N. Carey

Cor.—10-10-29—A Co.—100 Bks.

E 49409

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49409

CERTIFICATE OF DEATH

188-10

1-PLACE OF DEATH

City of Baltimore: (No. St Jos Hosp. St 18-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benj Arch Madden

(a) RESIDENCE NO. 518 Schroeder St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hortense Madden

6 DATE OF BIRTH (month, day, and year) June 9- 1901

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
28	3	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Asbury Madden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Evelyn Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Asbury Madden
(Address) 518 Schroeder st.

Filed SEP 2 1 1929 C. HAMPSON JONES, Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract Skull auto in which he was a ruder collided with beacon light - at intersection (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Rairwood & Belair Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Frame, M D.

9/19, 1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Lukes - Ruxton Md	9/25/1929
20 UNDERTAKER	ADDRESS
Jos. H. Holland	1631 Division Kildare

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49410

2 29 16

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 49410

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa Fortune

(a) RESIDENCE NO. 519 Gold ST., WARD 17-2
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-28-84

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	45	-	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Ind

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Bowser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Kate Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address)

15 Filed SEP 21 1929

C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18-1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Sept 18, 1929, that I last saw her alive on Sept 18, 1929 and that death occurred, on the date stated above, at 9 40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma, probably Ovary.

Duration unknown; several years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock following abdominal paracentesis, about 7 hours.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? Yes Date of Sept. 17, 1929.

Was there an autopsy? Yes. J.H.H. No. 11,112.

What test confirmed diagnosis? Autopsy.

(Signed) Raymond H. Sayler, M. D.

9/19. 1929 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Sept 21 1929

20 UNDERTAKER Thomas E Kelson — ADDRESS 303 Fressman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49411

CERTIFICATE OF DEATH

E 49411

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2107 Boston St., 1-1 Ward)

2-FULL NAME Charles Clement

(a) RESIDENCE NO. 2107 Boston St., 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.... hrs. or .... min.
	55	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) on farm
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Boston Mass

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Catherine Sweeney
(Address) Eastern ave Rod ext

15 Filed SEP 21 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) James M Kemper, M. D.
9/17/29 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Comfort	9/20/29
20 UNDERTAKER D. Kelly Zieler INC	ADDRESS 1210 W Fay

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49412

CERTIFICATE OF DEATH

E 49412

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 7069

CITY OF BALTIMORE: (No. Calvert & 33rd, ST. ..... WARD.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia Cruck

(a) RESIDENCE NO. 2132 W. Vine ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	9	6	

8 OCCUPATION OF DECEASED: None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Cruck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Gertrude Hyby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mother
(Address) 2132 W. Vine St. Balto. Md.

15 SEP 21 1928 G. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 21, 1929 that I last saw h.r alive on Sept 21, 1929 and that death occurred, on the date stated above, at 2:00 a. m.

The CAUSE OF DEATH* was as follows: Gastro-enteritis

(duration) About 1 yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Accidental Burns (Scalp)

(duration) About 1 mos. 11 ds.

18 Where was disease contracted if not at place of death? 2132 W. Vine St Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Swartzwelder M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedrale	Sept. 23 1929
20 UNDERTAKER Geo. W. Little	ADDRESS 2700 Edmondson Ave

Fill in all the plain items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 49413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 6 E 49413

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 6-9 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Schapiro

(a) RESIDENCE NO. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, 8 hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Ralph Schapiro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md

12 MAIDEN NAME OF MOTHER Ethel Maisel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Sept 21 1929

15 Sept 20 1929 . 19 per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929 to Sept 18, 1929.

that I last saw her alive on Sept 18, 1929.

and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonum

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Hemorrhage & Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Irvin B. Schapiro, M. D.

, 19 (Address) 2415 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Sept 20 1929

UNDERTAKER: (Commissioner Health,

ADDRESS

Per Jno E. Woodall.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49414

182

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Maryland Dry Dock, Fairfield 21-24 Ward)

2-FULL NAME William C. Tripp.

(a) RESIDENCE NO. 1101 Ward St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. ---- mos. ---- ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	31	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired soldier.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

056

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Tripp.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rose Weber.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Charles Tripp. (brother)
(Address) 1101 Ward St.

Filed SEP 21 1929 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 16, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Occicental fall from a boat.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

9/21, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U S Nat Cem

DATE OF BURIAL 9/21 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49415

CERTIFICATE OF DEATH

16-002

E 49415

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 132 S. Morley St. 22-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Loral Boblit.

(a) RESIDENCE NO. 132 S. Morley St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alford N. Boblit

6 DATE OF BIRTH (month, day, and year) Nov. 29, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER ? James.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rebecca James.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr. Milton C. Brooks

(Address) 132 S. Morley St.

15 Filed SEP 21 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1927; to Sept, 1929.

that I last saw her alive on Sept 19, 1929,

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Arthritis deformans.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bacillary Dysentery. (Shiga)

(daration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Stool Culture.

(Signed) Dr. Lloyd Johnson, M. D.

, 19 (Address) 4200 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept. 21, 1929
UNDERTAKER Wm. J. Burkert & Sons	ADDRESS North & Pa

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 49416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 49416

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Southern ~~Ave~~ St WARD)

2-FULL NAME Francis J. Winkel

(a) RESIDENCE No. 2600 Southern Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Winkel

6 DATE OF BIRTH (month, day, and year) March 12-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Eugene J Winkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary E. Welty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Eugene J Winkel

(Address) 2600 Southern Ave

15 Filed SEP 21 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1926, to Sept 19, 1929, that I last saw h alive on Sept 19, 1929 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Uremia Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Leonard M. D.

9/20/29 (Address) 718 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery Co	Sept 23 1929

20 UNDERTAKER Leonard J Peach ADDRESS 1403 Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

E 49417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

H+ E 49417

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1603 Cereal St. St. 25-77 Ward)

2-FULL NAME John Lindberg.

(a) RESIDENCE NO. 1603 Cereal St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Matilda Lindberg.

6 DATE OF BIRTH (month, day, and year) April 16, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith,
(b) General nature of industry, business, or establishment in which employed (or employer) B.&O. R.R.Co. D06
(c) Name of employer

9 BIRTHPLACE (city or town) Russia.
(State or country)

PARENTS

10 NAME OF FATHER John Lindberg.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Anna --------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia.

14 Informant Matilda Lindberg.(wife)
(Address) 1603 Cereal St.

15 Filed ..... 1929 C. HAMPSON JONES, M. D. Registrar

P 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 20, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cancer of the stomach.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Leinhardt, M. D.

9/21. 1929 (Address) 101 E. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill a. a. Co	Sept 23 1929
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light St.

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 49418

CERTIFICATE OF DEATH

E 49418

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 1816 E. 30th ST., 9-46 (WARD))

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John D. Stephan

(a) RESIDENCE NO. 1816 E. 30th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara A. Stephan

6 DATE OF BIRTH (month, day, and year): April 7. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Henry Stephan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. John D. Stephan

(Address) 1816 E. 30th St.

15 Filed SEP 21 1929, 19... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 19th 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 18. 1929. to Sept 19. 1929.

that I last saw h[illegible] alive on Sept 19. 1929

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Mitral insufficiency

(duration) 7 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Leuth M. D.

9/20. 1929 (Address) 4455 E Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	Sept 21 1929
20 UNDERTAKER: Margaret G. Flynn	ADDRESS: 1422 Light

IF DEATH IS plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 49419

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (ST.) (WARD)

2-FULL NAME Mrs. Mamie E Mauk.

(a) RESIDENCE NO. 1318 James ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of late Julius A Mauk.

6 DATE OF BIRTH (month, day, and year) Dec 11th 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	44	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

037

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sophie Rollmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md

14 Informant Mrs John V. Adams

(Address) 311 Cumberland

15 Filed SEP 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1929

17 I HEREBY CERTIFY, That I attended deceased from August 28, 1929, to Sept 20 1929, that I last saw her alive on Sept. 20 1929 and that death occurred, on the date stated above, at 6.35 p. m.

The CAUSE OF DEATH* was as follows:

Cirhosis of the Liver

(duration) 1½ yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J W Adams M.D.

(Address) W. Balto Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Sept 23rd 1929

20 UNDERTAKER John J Howard & Son

ADDRESS Woodlawn

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49420

CERTIFICATE OF DEATH.

56 E 49420

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1550 N. Bruce St. ST., ... WARD) 5-21

2-FULL NAME Shirley Dare

(a) RESIDENCE No. 1550 N. Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Charles Dare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Daisy Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manchaking, Va.

14 Informant Chas. Dare
(Address) 1550 N. Bruce St.

15 Filed SEP 1 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-16, 1929, to 9-20, 1929, that I last saw him alive on 9-20, 1929 and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Rickets (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Cullen Jr., M. D.

, 19 (Address) 516 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary Cem.	9-22 1929
20 UNDERTAKER	ADDRESS
Joseph A Lively	408 N Mount

DATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49421

REGISTERED No. E 49421

1-PLACE OF DEATH

City of Baltimore: (No. 1705 Lorman St., Ward)

2-FULL NAME Annie Frazier

(a) RESIDENCE NO. 1705 Lorman St., Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Holt Frazier

6 DATE OF BIRTH (month, day and year) Sept 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	41-	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Jos. Sisco.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Hankins

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Holt Frazier
(Address) 1705 Lorman

15 Filed ... 19... C. HAMPSON JONES, M. D.
By ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 18 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

Sept 18 19... (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Sept 21 1929

20 UNDERTAKER Thomas E. Keleon ADDRESS 303 Presstman

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Banks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49422

CERTIFICATE OF DEATH

46 ✓

E 49422
REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1905 McKean Ave. ST., WARD)

2—FULL NAME Cordelia Wilson Banks

(a) RESIDENCE NO. 1905 McKean Ave. ST., 15-71 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Herbert Banks

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank W. George

11 BIRTHPLACE OF FATHER (city or town) Baltimore Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret E. Timanus

13 BIRTHPLACE OF MOTHER (city or town) Baltimore County
(State or country) Maryland

14 Informant Miss Mary S. George

(Address) 1905 McKean Ave.

15 (S) HAMPSON JONES, M. D. Registrar

SEP 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from 1925 to Sept 18 1929.

that I last saw her alive on Sept 16 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Edema Pneumonia of the Lungs

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Carcinomatosis & cardiac dilatation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1926

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) Edw. Whiting M. D.

9/21, 1929 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery, Roslyn	Sept. 20 29
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 West Baltimore St.

Be sure the personal particulars, so important, are properly classified. Exact statement of OCCUPATION may be necessary for certificates. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Mary

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49423

CERTIFICATE OF DEATH

3/ E 49423

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Marx

(a) RESIDENCE NO. 1607 Cypress st. ST., 25-77 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Marx

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Marx

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 8, 19 29, to Sept. 19, 19 29, that I last saw him alive on Sept. 19, 19 29 and that death occurred, on the date stated above, at 9.25 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Thos. [illegible] M. D.

9-20, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept. 23, 1929
20 UNDERTAKER	ADDRESS
Frederick Leahman Sons	Fullerton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49424

CERTIFICATE OF DEATH

162 E 49424

REGISTERED NO.

1—PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Garland & Green ST., WARD) 21-29

2—FULL NAME Sister Seraf Hoffman

(a) RESIDENCE NO. 778 Carroll ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 16-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	6 5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Geo Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Anna M Kuecke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Geo Hoffman

(Address) 778 Carroll St

15 Filed SEP 22 1929 C. HAMPSON JONES M.D. Registrar

BY 5048

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Sept 21, 1929

that I last saw him alive on Sept 21, 1929

and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Hemorrhagic disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. S. Johnson M. D.

9/21, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 9-23 1929

20 UNDERTAKER Robert Brooke & Son — ADDRESS Calhoun & Hollins

IMPORTANT. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49425

CERTIFICATE OF DEATH. 7-4-001

E 49425

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., Ward)

2-FULL NAME Allen Gunkbone (Gunkbone)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 154 Bay St. 4-7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred under yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 5 Months 6 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Employer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address) C. Hampson Johns Hopkins Hosp.

15 Filed Sept 21 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Appendicitis 2 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) 4 days yrs. mos. ds.

(Signed) A. T. Riley M. D.

(Coroner)

Sept 21 1929 (Address) 6439 Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark Ohio Date of Burial Sept 23 1929

20 UNDERTAKER Geo A Farley ADDRESS 1808 E Fayette St

P 22 1929

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 49426 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md. REGISTERED NO. X 131

CITY OF BALTIMORE: (No. ..... ST., WARD) 2-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Jubino

(a) RESIDENCE NO. 1635 Thames St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Water tender

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. Munbeaver

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER Manuel Jubino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Elvira Lugris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Records, U.S. Marine Hospital (Address)

15 C. HAMPSON JONES, M. D. Registrar

P 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 10 19 29 to Sept. 20 19 29, that I last saw him alive on September 20 19 29 and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary,

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. & x-ray

(Signed) Ralph E Porter M. D.

9/21, 19 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Sept 23 1929

20 UNDERTAKER E. LeRoy Stiffler, Inc. ADDRESS 125 E. North ave

mation should be carefully supplied. AGE CAUSE OF DEATH must be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificate. that it may be properly classified. Exact statement of OCCUPA-

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49427

E 49427

188-103

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hosp. St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Armstrong 19-79

(a) RESIDENCE NO. 1304 W Pratt St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 1 1925

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	4	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant X

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harrisonburg

(State or country) Virginia

PARENTS

10 NAME OF FATHER Eddie Armstrong

11 BIRTHPLACE OF FATHER (city or town) Harrisonburg

(State or country) Va.

12 MAIDEN NAME OF MOTHER Ruth Armstrong

13 BIRTHPLACE OF MOTHER (city or town) Harrisonburg

(State or country) Va.

14 Informant Elmer Swartz

(Address) Dayton, Va.

15 Sept 22 1929 C. HAMPSON JONES, M. D. Registrar

By H

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Fract Skull

Shock by an automobile

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

9/22 19 29 (Signed) D. Frame M. D. (Coroner)

(Address) 1939 W Eden

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisonburg, Va. Date of Burial Sept 22 1929

20 UNDERTAKER Geo. D. Cook ADDRESS 1003 W. Pratt St.

THIS IS A PERMANENT RECORD. Every item must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49428

CERTIFICATE OF DEATH

× 16-002 E 49428

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (Name of Hosp. ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Carl Schmidt Jr. 12-49

(a) RESIDENCE NO. Randallstown, Md ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Randallstown, Md.
(State or country)

PARENTS

10 NAME OF FATHER Carl David Schmidt

11 BIRTHPLACE OF FATHER (city or town) Long Green Balt. mors.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen E. Burnham Helen Burnham

13 BIRTHPLACE OF MOTHER (city or town) Randallstown
(State or country) Md.

14 Informant Mrs. Carl D. Schmidt
(Address) Randallstown, Md.

15 Filed SEP 22 1929, 19.. C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1929, to Sept. 21, 1929
that I last saw him alive on Sept. 21, 1929
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Acute bacillary Dysentery

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Randallstown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. E. Mathis, M. D.

9-21-1929 (Address) Randallstown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olive Cemetery, Roslyn	Sept. 23 19 29
UNDERTAKER Joseph B. Cook	ADDRESS 1003 East Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Blks.

Dr Jones ✓ 720 N Wolfe Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49429

CERTIFICATE OF DEATH

47 E 49429

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4982 Dunmore Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie L. Curtis Age 27-56

(a) RESIDENCE NO. 4982 Dunmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	10 11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant E N Johnson

(Address) 4982 Dunmore Ave

15 Filed SEP 22 1929, 19

Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 19 29, to Sept 20, 19 29, that I last saw her alive on Sept 20, 19 29 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast (metastasis of brain)

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 9/8/28

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones M. D.

9/21, 19 29 (Address) 720 N Wolfe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gaddockville, Va — DATE OF BURIAL 9/22 1929

20 UNDERTAKER Wm. Cook — ADDRESS 1211 E Pratt St

IMPORTANT.—Fill out CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49430

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49430

CERTIFICATE OF DEATH. X 47

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 901 Ausgusta ST., WARD 10-14)

2-FULL NAME Sr. M. Angeline Devan

(a) RESIDENCE No. Sisters of Notre Dame ST., WARD Brooklyn N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER John Devan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Bridget Donahue

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Sisters of Notre Dame
(Address) 701 Augusta

15 9 20 1929 . 19 . C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 September 1929

17 I HEREBY CERTIFY, That I attended deceased from 12 September, 1929, to 19 September, 1929, that I last saw her alive on 19 September, 1929, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma lungs - from primary Carcinoma breast

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brooklyn N. Y.

Did an operation precede death? yes Date of 2/25/1890

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) F. J. Finley, M. D.

9/20 1929 (Address) 110 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Md — DATE OF BURIAL Sept 23 1929

20 UNDERTAKER Frank A. Fink — ADDRESS 913 N. Gay St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 49431

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49431

CERTIFICATE OF DEATH.

7H-002

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Monument + Broadway ST., WARD) 8-16

2-FULL NAME Louis Fedder

(a) RESIDENCE NO. 1612 - N. Post ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Fedder

6 DATE OF BIRTH (month, day, and year): July 4 - 1885

7 AGE: Years 44 Months 2 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: William Fedder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca Levinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Annie Fedder

(Address): 1612 N Port St

15 [illegible] 1929 . 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/20 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 16 . 1929 . to Sept 20 . 1929.

that I last saw h/M alive on Sept 20 . 1929.

and that death occurred, on the date stated above, at 5:38 A .m.

The CAUSE OF DEATH* was as follows:

Cavernous Sinus Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cellulitis of Face

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Johnson . M. D.

9/21 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rebecca Rosedale

DATE OF BURIAL: 9/22 1929

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balt St

SEP 22 1929

mation should be carefully supplied. AGE
• CAUSE OF DEATH in plain terms, so that i
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 49432

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49432

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., WARD) 13-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman A. Steedle

(a) RESIDENCE NO. 2217 Mondawmin Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Steedle

6 DATE OF BIRTH (month, day, and year) Sept 8-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	46	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Steedle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hattie Steedle

(Address) 2217 Mondawmin Ave

15 Filed SEP 22 1929, 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1929, to Sept. 20, 1929,

that I last saw him alive on Sept. 20, 1929,

and that death occurred, on the date stated above, at 10:00 A m.

The CAUSE OF DEATH* was as follows:

Alcoholic Hepatic Septicaemia (Staphylococcus)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia Post operative

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/15/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & blood culture

9/20, 1929 (Signed) Benj H Klotz, M. D.

(Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lehren Washington Rd

DATE OF BURIAL 9/22, 1929

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be p
TION is very important. See instructions on back of c
of certificates.

P 22 1929

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49433

CERTIFICATE OF DEATH

101-00 E 49433

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) 19-79

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Friedman

(a) RESIDENCE NO. 1335 Ramsey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. ?mos. ?ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 80

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed SEP 22 1929, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 19 29, to Sept. 20, 19 29,

that I last saw him alive on Sept. 20, 19 29

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

9-21, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dehsen Rosedale — DATE OF BURIAL 9/22/1929

20 UNDERTAKER Jacob Lewis — ADDRESS 1439 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49434

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49434

CERTIFICATE OF DEATH.

49

REGISTERED NO. 15-71

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland Aves ST., 207 WARD)

2-FULL NAME Lena Fine

(a) RESIDENCE NO. 1526 N Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Fine

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
1884	45	47		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Bloch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Brempston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mr. Frankel

(Address) 1526 N Payson St

15 Filed SEP 22 1929, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/21 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to Sept 21, 1929, that I last saw h er alive on Sept 21, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas & metastases

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pn (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 4.

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) W Blocher Brumbey M. D.

9/21, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 9/22 1929

20 UNDERTAKER Weh Levin

ADDRESS 1489 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 49435

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 N Carey ST., WARD) 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Gettinger

(a) RESIDENCE NO. 631 N. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Gettinger

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emma Pentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant William Gettinger

(Address) 631 N. Carey St.

SEP 2 1929, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1929, to Sept 19, 1929, that I last saw h[illegible] alive on Sept 19 1929 and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

Undetermined

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) J. Carl Schmidt M. D.

Sept 20 1929 (Address) 1134 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Woods

DATE OF BURIAL 9-23 1929

UNDERTAKER Bernard Carlon

ADDRESS 976 Baltimore

MAY be properly classified. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49436

CERTIFICATE OF DEATH

188-006

E 49436

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., Ward)

2-FULL NAME Thomas Ehrman

24-35

(a) RESIDENCE NO. 1433 Hull St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine (Krach) Ehrman

6 DATE OF BIRTH (month, day, and year) May 10/1898

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	31	4	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedor
(b) General nature of industry, business, or establishment in which employed (or employer) Munson Steamship
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Frederick Ehrman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hoff

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Catherine Krach
(Address) 1433 Hull St

15 Filed 19 C. HAMPSON JONES, M. D.
Registrar

Per

P 2 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 20/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Hemorrhage. Injuries to spine thorax & intra abdominal. Accidentally crushed while loading Co) steel rails in hold of ship.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Carr M. D.

9-21-19 (Address) 506 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 23 1929
20 UNDERTAKER Chas L. Stevens	ADDRESS Essex, Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Un-0377

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49437

CERTIFICATE OF DEATH

86-001

E 49437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., Ward)

2-FULL NAME Jerone Hughes 7-13

(a) RESIDENCE NO. 1522 E. Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7/29

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Hallie Hughes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Hughes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant James Hughes
(Address) 1522 E. Monument St

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

SEP 22 1929 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 20/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (1t frontal region)
Bilateral Otitis Media
Rickets

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? Yes at Hopkins

What test confirmed diagnosis?

(Signed) Jos Carter, M. D.

9/22/29 (Address) 508 E. Joria Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bury Cemetery	Sept 23 1929
20 UNDERTAKER	ADDRESS 1631
Edward Bryan	Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 49438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49438

CERTIFICATE OF DEATH.

148

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home and Infirmary (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Pavak Kitko

(a) RESIDENCE NO. 1234 South Decker Avenue WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (~~If single, of~~) or) WIFE of Andrew Martin Kitko

6 DATE OF BIRTH (month, day, and year) June 9 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	18	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Pavak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Husband (Address)

15 Filed SEP 21 1929, 19.., C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 21 1929

17 I HEREBY CERTIFY, That I attended deceased from 10:10 A.M. Sept. 19, 1929, to 1:40 A.M. Sept. 21, 1929, that I last saw her alive on September 21, 1929, and that death occurred, on the date stated above, at 1:40 A. m.

The CAUSE OF DEATH* was as follows:

Antepartum Eclampsia 40 hours (duration) yrs. mos. One ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema 36 hours (duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John G. Murray Jr. M. D.

Sept. 21 1929 (Address) 9 East Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL Sept. 24 1929

20 UNDERTAKER Chas. S. Brachlon — ADDRESS 1906 Eastern Ave

P 22 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49439

CERTIFICATE OF DEATH

31

E 49439

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 105 S. Bond St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Louis Palmer 3-4

(a) RESIDENCE NO. 105 S. Bond St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Palmer

6 DATE OF BIRTH (month, day, and year): Dec 25 / 1902

7 AGE: Years 26 Months 8 - 25 Days 24 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): for self. 37

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Henry Lewis

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Susie St. John

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): U. S.

14 Informant: Estelle Mason

(Address): 704 Carlton St

15 Filed ..... C. HAMPSON JONES, Registrar M. D.

By ..... M H

SEP 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 19 / 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Sept 19, 1929

that I last saw h.r alive on Sept 18 / , 1929

and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) L. O. Earlington, M. D.

, 19 (Address) 1514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: Sept 22, 1929

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1725 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 49440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 49440

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 602 Gold St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Handy 15-71

(a) RESIDENCE NO. 602 Gold St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: The late Benjamin Handy

6 DATE OF BIRTH (month, day, and year): September 14 1867

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62 years		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: —

9 BIRTHPLACE (city or town): _____

(State or country): Liverpool England.

PARENTS

10 NAME OF FATHER: Harry Jones

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Unknown

14 Informant: Mary Hyman

(Address): 602 Gold st

15 C. HAMPSON JONES, M. D. Registrar

Date: SEP 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Sept 19. '29

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Sept 19, 1929, that I last saw h[illegible] alive on 9-19-29, 19____, and that death occurred, on the date stated above, at 8:24A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

sudden ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Sudden pending Dilly

Antecd Sclerosis (duration) ... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) Eugene Sutton, M. D.

, 19 (Address) 602 Gold Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Date of Burial Sept 22 1929

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS: 1323 Eastlander

P 2 21929

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49441

CERTIFICATE OF DEATH

x 38 E 49441

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St.) Ward)

2-FULL NAME Bernice Willis

(a) RESIDENCE NO. Sparrows Point Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20-29

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	3	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Grace Willis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Sarah Savage
(Address) Sparrows Point, Md.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

2 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 20-29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cogenital Syphillis
Acute Intestinal Indigestion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) H H Poe M. D.

9-22-29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashley Cemetery	Sept 23 1929

20 UNDERTAKER Chas. H. Johnson ADDRESS 416 N. Carolina

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49442

90 E 49442

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 743 E. 37th St., Ward)

2-FULL NAME Lillie M. Cockey

9-47

(a) RESIDENCE NO. 743 E. 37th St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. - mos. - ds. How long in U. S., if of foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas L. Cockey

6 DATE OF BIRTH (month, day, and year) November 23, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kent County
(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Conner

11 BIRTHPLACE OF FATHER (city or town) Kent Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary V. Hewett

13 BIRTHPLACE OF MOTHER (city or town) Kent Co.
(State or country) Maryland

14 Informant Nicholas L. Cockey
(Address) 743 E. 37th Street

15 Filed SEP 22 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 20-29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency (Valvular)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

9/21/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	9/23 1929

20 UNDERTAKER Henry W. Myers, Inc. ADDRESS 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Brown

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49443

CERTIFICATE OF DEATH

31

E 49443

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1715 Ensor St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Brown

(a) RESIDENCE NO. 1715 Ensor Street ST., 9-18 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Brown

6 DATE OF BIRTH (month, day, and year) 6/10/1886

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	43	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Wm. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Hattie McFarland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mabel Brown

(Address) 1715 Ensor St

15 Filed SEP 22 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 19 29, to Sept 20, 19 29

that I last saw him alive on Sept 19, 19 29,

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robt Gray M.D.

9/21/29 (Address) 627 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	9/23/29

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49444

CERTIFICATE OF DEATH

47 E 49444

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3217- Belair Rd. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma N. Renner

(a) RESIDENCE NO. 3217- Belair Rd ST., 8-40 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas A. Renner

6 DATE OF BIRTH (month, day, and year) Apr. 3. 1891

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	38	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John J. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Olson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14

Informant Thomas Renner

(Address) 3217- Belair Rd

Filed SEP 22 1929, 19

Per

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20-1929

17

I HEREBY CERTIFY, That I attended deceased from May 16- 1927, to Sept. 20- 1929, that I last saw her alive on Sept. 18. 1929 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 1928

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj. D. Hampson M. D.

9/24. 1929 (Address) 1216 N. Carolina at

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	9/23 1929
20 UNDERTAKER George J. Kuhl	ADDRESS 1735 Hanford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49445

CERTIFICATE OF DEATH.

89 E 49445

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 415-S. Spring St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Brown

(a) RESIDENCE NO. 415-S. Spring St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Brown

6 DATE OF BIRTH (month, day, and year): 9/1/1872

7 AGE: Years 57 | Months — | Days 19 | IF LESS than 1 day .....hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Tillman

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mahoney

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): "

14 Informant: James Brown

(Address): 415-S. Spring St.

SEP 21 1929

C. HAMPSON JONES, M. D. Registrar

Fee

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) James M Benton M. D. (Coroner)

9 21 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? 415 S Spring St

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem. Date of Burial: 9/24/29

20 UNDERTAKER: Geo. J. Pfeltz ADDRESS: 1725 Hanford

SB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49446

CERTIFICATE OF DEATH

90 E 49446

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1615-N. Chapel ST., WARD)

2—FULL NAME Henry C. Walter

(a) RESIDENCE NO. 1615 N. Chapel St. ST., 8 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna G. Walter

6 DATE OF BIRTH (month, day, and year) 2/17/1890

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
39	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna G. Walter

(Address) 1615 - Chapel St

15 Filed P 2 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from September 15, 1929, to September 21, 1929, that I last saw h.. alive on September 20, 1929 and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

1) Rheumatic Cardiovascular Disease
a) Mitral Insufficiency
b) Aortic Stenosis

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Passive Congestion

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Tenner (Tenner) M. D.

9/21/29 19 (Address) 1703 Springfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 9/24/29 19

20 UNDERTAKER Geo. J. Kelly Sons — ADDRESS 1225 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49447

CERTIFICATE OF DEATH

× 129 E 49447

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clinton Christie

(a) RESIDENCE NO. Frederic, Md. ST., 129 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 0&b

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER T. W. Christie

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Laura Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 23 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1929, to Sept 22, 1929, that I last saw h. alive on Sept 22, 1929 and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

Chronic nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic alcoholism

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Ruth E Faubault, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet.	9/24 1929
UNDERTAKER	ADDRESS
[illegible]	Frederick Md

Information should be carefully supplied. Any error should be corrected. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 40448 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 49448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 752 Washington B'l'v'd. St., —— Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charlotte Gatkenheimer

(a) Residence No. 752 Washington B'l'v'd. St., — Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Christian F. Gatkenheimer

6-DATE OF BIRTH (month, day and year) Nov. 9, 1848

7-AGE. 80 yrs. 10 mos. 12 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... housework at home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Heckel

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

11- (Informant) Wm F. Gatkenheimer

(Address)... 752 Washington Blvd.

15- Filed SEP 23 1929 19.. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 21, 1929

17- I HEREBY CERTIFY, That I attended deceased from Aug. 22 19 29 to Sept 21, 19 29

that I last saw her alive on Sept. 20, 19 29

and that death occurred, on the date stated above, at 4.35 a. m.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis

about 1 (Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) cardiac failure

(Duration) yrs. 1/2 mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) George A. Kuipp M. D

, 19 (Address) 3030 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept 23 1929
20-UNDERTAKER.	ADDRESS
C. O. Hufnagel	1850 N. Bond St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49449

45

E 49449

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3213 Ravenwood Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Schiminger

(a) RESIDENCE NO. 1918 Riggs Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 8 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Herman Schiminger

6 DATE OF BIRTH (month, day, and year) Dec 22 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75 77	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER — Grinder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Boedt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Klein

(Address) 3213 Ravenwood Ave.

15 Filed SEP 23 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to Sept. 20, 1929

that I last saw her alive on Sept. 19, 1929

and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Ascend'g Colon with Metastasis to Liver.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1918 Riggs Ave.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. & Clinical Signs

(Signed) Carlos L. Briggett, M. D.

, 19 (Address) 1015 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvert	Sept 23 1929
20 UNDERTAKER J. F. B. Hippert	ADDRESS 1850 N. Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49450

CERTIFICATE OF DEATH

52 ✓ E 49450

1—PLACE OF DEATH Home for Incurables — REGISTERED NO.

CITY OF BALTIMORE: (No. 46th St. + Cedar Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosia A. Alta Chaney

(a) RESIDENCE NO. 1017 W. Hanvale ST., 16-23 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs 11 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William Chaney

6 DATE OF BIRTH (month, day, and year) Aug 5, 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Matilda Marsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County

14 Informant Sister

(Address)

15 Filed SEP 23 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21" 29

17 I HEREBY CERTIFY, That I attended deceased from October 30, 19 28, to Sept 20", 19 29

that I last saw her alive on Sept 20", 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Arthritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) W. W. B. Mayo, M. D.

Sept 28" 29 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ward Chapel Balto Co Md	Sept 28 19 29
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Sons	N. Paca Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

73 V E 49451

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Adelaphine ~~Adele~~ Iglehart (Adelaphine Iglehart)

(a) RESIDENCE NO. 516 N. Paca ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 7 3 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	60	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. Iglehart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adele Hubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

SEP 23 1929 Filed HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1929, to Sept. 20, 1929

that I last saw her alive on Sept. 20, 1929

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Coronal Sclerosis (Cerebral Embolism)

(duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ; Hypertension

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path. Lab.

(Signed) Warren H. Wheaton, M. D.

9-21, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Sept 23 1929
20 UNDERTAKER	ADDRESS
J. J. Lechner, Jr.	[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

58-001 ✓ E 49452

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2903 Keyworth Ave. ST., WARD) 15 58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah Johnson

(a) RESIDENCE NO. 2903 Keyworth Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6-1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Mrs. Edw. E. Schlutter

(Address) 2903 Keyworth Ave.

15 Filed 6a HARRISON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1929

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to Sept 20, 1929

that I last saw her alive on Sept 19, 1929

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. S. Lloyd, M. D.

19 (Address) 223 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park Cem. DATE OF BURIAL Sept 23 29

20 UNDERTAKER Wm. Fluckner Sons ADDRESS North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49453 — **CERTIFICATE OF DEATH** — 129 — **E 49453**

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3639 Resterstown Rd. ST., Roric WARD) 5.58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sadie Horner Horsey

(a) RESIDENCE NO. 3639 Resterstown Rd. ST. Roric WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W. Horsey

6 DATE OF BIRTH (month, day, and year) Feb. 28-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
61	60	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Alexander Haner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mrs Jennie Heitmian (Address) 3639 Resterstown Rd

15 Filed SEP 23 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 29

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929 to Sept 19, 1929.

That I last saw h.. alive on Sept 18, 1929

and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

1. Chronic nephritis

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Pneumonia Lobular

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clifton T. Lee M. D.

9/20/29 (Address) 606 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Ridge — DATE OF BURIAL Sept. 23, 1929

UNDERTAKER D. [illegible] Tickner & Son — ADDRESS Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 49454

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49454

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 411 E Hamburg St., _____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lane Donna Aikey 2 + 33

(a) RESIDENCE NO. 411 E Hamburg St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): (

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 9.2 1928

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Balto md

(State or country)

PARENTS

10 NAME OF FATHER: Olen Oscar Airey

11 BIRTHPLACE OF FATHER (city or town): Cambridge Md

(State or country)

12 MAIDEN NAME OF MOTHER: Mary E Breeden

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Mrs Mary Airey

(Address): 411 E Hamburg

15 Filed SEP 23 1929

HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9 21 1929

17 I HEREBY CERTIFY, That I attended deceased from 8.25, 1929, to 9.21, 1929, that I last saw her alive on 9.21, 1929, and that death occurred, on the date stated above, at 9.0.C. m.

The CAUSE OF DEATH* was as follows:

Donalsims

(duration) yrs. 2 Weeks mos. ds.

CONTRIBUTORY (Secondary): Irreg Nistery Pertusis 4 Weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Zankmun

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Livingston, M. D.

, 19 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — Date of Burial: Sept 23 1929

20 UNDERTAKER: John F Denny — ADDRESS: 715 L St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49455

159-003

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 E Grindall St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peggy M Wrightson

(a) RESIDENCE NO. 418 E Grindall St. WARD 24-33

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	W	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 13 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles R Wrightson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mildred M Herbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Chas R Wrightson

(Address) 418 E Grindall St

15 Filed SEP 23 1929 S. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22/1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1929, to Sept. 22, 1929.

that I last saw her alive on 9/22 1929

and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Spina Bifida

Probably (duration yrs. mos. ds)

CONTRIBUTORY (Secondary) Rupture of Regurgitating Mitral Valve & Spinality of Medulla (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? No Date of —

Was there an autopsy? Is to be

What test confirmed diagnosis? Clinical observation

(Signed) E. A. Libanger, M. D.

9/22, 1929 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 23 1929
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr. Niblett 2220 Garrison Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49456

CERTIFICATE OF DEATH

129 ✓

REGISTERED NO. **E 49456**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3619 Ferndale Ave WARD) 28-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Kruse

(a) RESIDENCE NO. 3619 Ferndale Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederic Louis Kruse

6 DATE OF BIRTH (month, day, and year) May 15 1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John H. Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lillian Kruse

(Address) 3619 Ferndale Ave

15 SEP 23 1929 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to Sept 20, 1929

that I last saw h[illegible] alive on Sept 20 about 1929

and that death occurred on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Jaundice - due to post operative adhesions - myocarditis

Nephritis - parenchymatous

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1925

Was there an autopsy? Yes

What test confirmed diagnosis? Surgical + Lab.

(Signed) W. S. Niblett, M. D.

9/23/29 (Address) 2220 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery Balto Md	9/23 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Sper.—2-29-28—L. F. S.—500 Bks.

E 49457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 ✓ E 49457

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 E. 31st St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L. McKhardt 9-46

(a) RESIDENCE NO. 1821 E. 31st St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis McKhardt

6 DATE OF BIRTH (month, day, and year) Aug 12 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary L. Wiles

(Address) 1821 E. 31st St.

15 Filed ..... 19 ..... Registrar

SEP 23 1929 HAMPSON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1929 to Sept 20th 1929

that I last saw her alive on Sept 20 1929

and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) K. K. Cody M. D.

9-21, 1929 (Address) 428 Dorford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Sept 23 1929
20 UNDERTAKER	ADDRESS
Philip Herwig	Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49458

CERTIFICATE OF DEATH

E 49458

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 9-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John George Pfeiffer

(a) RESIDENCE NO. 3 Oriole Ave ST., WARD Colgate, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred non-resident. How long in U. S., if foreign born? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Pfeiffer

6 DATE OF BIRTH (month, day, and year) April 5, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture finisher

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John J. Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Denelle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Marie Pfeiffer

(Address) 3 Oriole Ave Colgate

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Sept 22, 1929, that I last saw him alive on Sept 21, 1929 and that death occurred, on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows:

Streptococcic Cellulitis of Left Side of Face (following abscess of Lt Upper molar tooth)

(duration) 0 yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary) Probably left cavernous sinus thrombosis (duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? 3 Oriole Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Isley M. D.

9-22, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edlah Farm DATE OF BURIAL 9/25 1929

20 UNDERTAKER Philip Fravg. ADDRESS 246 Orle

N. B.—WHITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49459

CERTIFICATE OF DEATH

129 ✓ **E 49459**

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2816 Suffolk ave ST., WARD) 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Elizabeth Harr

(a) RESIDENCE NO. 2816 Suffolk ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M.

If married, widowed, or divorced: (or) WIFE of Howard R Harr

6 DATE OF BIRTH (month, day, and year) Mar 30 81

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles H Sittig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosie Hirshman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Howard R Harr

(Address) 2816 Suffolk ave

15 Filed SEP 23 1929 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21, '29

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929, to Sept 21, 1929, that I last saw her alive on Sept 20, 1929 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Julian S Bishop, M. D.

Sept. 23, 1929 (Address) 132 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lutheran Cemetery Baltimore	Sept 23 1929
20 UNDERTAKER W Maurice Routson	ADDRESS 223 E Mt Royal ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49460

CERTIFICATE OF DEATH

E 49460

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sister Mary Mercedes

(a) RESIDENCE NO. Sister de Salles Convent ST., Catonsville Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23/29

17

I HEREBY CERTIFY, That I attended deceased from 9/6/29, 19..., to 9/23, 19 29

that I last saw h er alive on 9/23, 19 29

and that death occurred, on the date stated above, at 1 17 A.m.

The CAUSE OF DEATH* was as follows:

Malignancy ovary and caecum.

(duration) yrs. 3 (?) mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/20/29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Wm H. McShane, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. DeSales Cem	Sept 24 1929
B. UNDERTAKER Easton Sons	ADDRESS Ellicott City

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

E 49461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x117 ✓ E 49461

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Mem. Hosp. ST., WARD)

REGISTERED NO. 17-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wiley D. Brown

(a) RESIDENCE NO. Charleston, N.C. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Wiley D. Brown

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Dairy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ellen Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Mrs. Wiley D. Brown

(Address) North Carolina

SEP 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1929, to Sept. 21, 1929, that I last saw h... alive on Sept 21, 1929 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Inflam. Disease of Caecum

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Charleston, S.C.

Did an operation precede death? Yes. Date of Aug. 17, 1929.

Was there an autopsy? No.

What test confirmed diagnosis? Resp. Comm.

(Signed) A. R. Wilkerson M. D.

. 19 (Address) Univ Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charleston, S.C.	Sept 21 1929
UNDERTAKER Colen O. Mitchell & Son	ADDRESS 190 Eaton Place

IMPORTANT: AGE should be carefully supplied. AGE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49462 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 101-001 E 49462

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 32nd & Calvert ST., WARD) 12-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mamie K. Clark

(a) RESIDENCE NO. Inverness ST., WARD Florida.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie K. Clark.

6 DATE OF BIRTH (month, day, and year) Dec 2, 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER B P Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Alivia Keels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina.

14 Informant The Deceased (Address) Hospital Record

15 Filed SEP 23 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23/29

17 I HEREBY CERTIFY, That I attended deceased from 9/19, 19 29, to 9/23, 19 29, that I last saw h.r alive on 9/23/29, 19 ..., and that death occurred, on the date stated above, at 12.45 A.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage, Apoplectic gastric

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/18/29

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. Brain removed

(Signed) Samuel McC Lambeth, M. D.

Sept 23, 1929 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Inverness Florida	Sept 25, 1929

20 UNDERTAKER Henry H. Hutchinson Sons Co ADDRESS 22 Chestnut St. Orchard 10

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49463 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 100-001 E 49463

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 26 WARD) 4-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan R Baker

(a) RESIDENCE NO. 6245 12th ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred whole life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 46 08

(b) General nature of Industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) unknown (State or country) Maryland

PARENTS

10 NAME OF FATHER Ashton Throly

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Maryland

14 Informant Balto City Hosp Records (Address) Balto City Hosp.

15 Filed ..., 19 ... Registrar

SEP 3 1929 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20-29

17 I HEREBY CERTIFY, That I attended deceased from 1-29-, 1929, to 9-20, 1929 that I last saw h[illegible] alive on 9-20, 1929 and that death occurred, on the date stated above, at 12 15 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) senility

(duration) unknown mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Fred M. Dunkwall, M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Sept 23rd 1929
20 UNDERTAKER Lilly & Geiser Inc	ADDRESS 403 S. Wolfe

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49464

CERTIFICATE OF DEATH

89 ✓ E 49464

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4900 Park Heights ave. WARD) 27-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Augusta Rees.

(a) RESIDENCE NO. 4900 Park Heights ST. ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Abel J Rees

6 DATE OF BIRTH (month, day, and year) Aug 25th 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Sarah Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md.

14 Informant Mary A Rees

(Address) 4900 Park Heights ave

15 Filed SEP 23 1929, 19 G. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22/1929

17 I HEREBY CERTIFY, That I attended deceased from several years, 19, to Sept 21, 1929, that I last saw h[illegible] alive on Sept 21, 1929 and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Angina Pectoris & complicating Gout (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? during life

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Barnett B Gatlin, M. D.

19 (Address) 1404 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cholerstown, Md.	Sept 24 1929
20 UNDERTAKER	ADDRESS
Stewart & Mowen Co.	1084 W. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 49465

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49465

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospl St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arbid C. Hager

(a) RESIDENCE NO. Midcity Hotel-228 W. Monument St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence M. Hager

6 DATE OF BIRTH (month, day, and year): Dec-15-1893

7 AGE: Years 35 Months 10 Days 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brick-layer

(b) General nature of industry, business, or establishment in which employed (or employer): Brick-laying

(c) Name of employer: Midwest Incinerator Co.

9 BIRTHPLACE (city or town): Duluth

(State or country): Minn.

PARENTS

10 NAME OF FATHER: Andrew Hager

11 BIRTHPLACE OF FATHER (city or town): Stockholm

(State or country): Sweden

12 MAIDEN NAME OF MOTHER: Carrie Larson

13 BIRTHPLACE OF MOTHER (city or town): ? ?

(State or country): Sweden

14 Informant: Mrs Florence M. Hager

(Address) 303-E-8th St. Duluth Minnesota

Filed SEP 23 1929, 19 C. HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture base of Skull accident

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. 2 mos. ds.

(Signed) James H Larson M. D. (Coroner)

Sept 22 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 3 ds. In the State yrs. 6 mos. ds.

Where was disease contracted, if not at place of death? 1611 Eutaw St

Former or usual residence Midcity Hotel

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Duluth, Minnesota — Date of Burial: Sept 27 1929

UNDERTAKER: Stewart & Mowen Company — ADDRESS: 108 N North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 49466 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home) (St.) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charles F Patterson

(a) RESIDENCE No. 213 7th (St.) WARD Washington D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
abt 59		0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Market Master

(b) General nature of industry, business, or establishment in which employed (or employer) Market - 886

(c) Name of employer U. S. Government -

9 BIRTHPLACE (city or town) (State or country) Fairfax Virginia

PARENTS

10 NAME OF FATHER Alfred Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Immaterial Va.

12 MAIDEN NAME OF MOTHER Isabella Innes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Immaterial Va.

14 Informant Mr J W Craig (Bro-in-Law)
(Address) 3417 Brideshead Lane.

15 Filed SEP 23 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-19-, 1929, to 9-22, 1929.

that I last saw him alive on 9-22, 1929.

and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

334 (1)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Malaria Duration unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture & Smears

(Signed) Edwin B Hall, M. D.

, 19 (Address) Church Home & Infd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lincoln - Pal.	Sept 24 1929.
UNDERTAKER	ADDRESS
Stewart Memorial Co	Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49467

CERTIFICATE OF DEATH

88 ✓

E 49467

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1039 W. Lexington St. 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Selenia White

(a) RESIDENCE NO. 1039 W. Lexington ST. 17th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jack White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Smallwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary White
(Address) 1039 W Lexington

15 Filed ____, 19____ ____ Registrar

SEP 28 1928 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/29

17

I HEREBY CERTIFY, That I attended deceased from August 5th, 1929, to Sept. 20th, 1929, that I last saw her alive on Sept. 20th, 1929, and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis.

(duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Pyaretic injection

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Test.

(Signed) J. T. Turner, M. D.

. 19 (Address) 512 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	9-23 1929
20 UNDERTAKER	ADDRESS
Daniel Easton	512 Ark Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 49468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49468

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Smallwood

(a) RESIDENCE NO. 807 George St. ST., 17-26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ?ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Merce Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Liza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed SEP 23 1929 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1929 to Sept. 21, 1929

that I last saw him alive on Sept. 21, 1929

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Toxic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency;

Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist: PE: Lab

(Signed) Harvin W. McLaw, M. D.

9-21, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9-23 1929
20 UNDERTAKER	ADDRESS
Daniel Carter	916 Pine

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49095
~~E 49469~~

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

7H-001 E 49469

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2 JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Irby

(a) RESIDENCE NO. 1635 Barnes St ST., 7-13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Ada

6 DATE OF BIRTH (month, day, and year): 4-9-84

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Everet Irby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Betty Blackwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 23 1929 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept-20-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Sept 20, 1929, that I last saw h. im alive on Sept 20, 1929 and that death occurred, on the date stated above, at 9 25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Leathe D Chamberlain, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	9-23 1929
20 UNDERTAKER: Daniel Easton & Son	ADDRESS 946 Park ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49470 E 49470

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Quigley

(a) RESIDENCE NO. 528 S Curley ST., 1-4 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Launders

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry 044

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Amos Quigley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Henrietta Wright

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hosp Record

(Address) Balto City Hospital

15 Filed SEP 23 1929, 19 HARRISON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21-29

17 I HEREBY CERTIFY, That I attended deceased from 7-22-, 1929, to 9-21-, 1929, that I last saw h alive on 9-21-, 1929 and that death occurred, on the date stated above, at 5-20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 4 da.

CONTRIBUTORY (Secondary) Carcinoma of pylorus and of stomach (duration) Unknown

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 8-1-1929

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Fred M. Ouckama M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	Sept 25 1929
20 UNDERTAKER Geo M. Fairchild Son	ADDRESS 811 N Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49471

CERTIFICATE OF DEATH

90

E 49471

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 821 Bradley St., ... Ward)

2-FULL NAME Olivia Coxson

(a) RESIDENCE NO. 821 Bradley St., 17-6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Coxson

6 DATE OF BIRTH (month, day, and year): Mar 15 - 1875

7 AGE: Years 54 | Months 5 | Days 5 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer): 041
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Emma Coxson
(Address) 821 Bradley

15 Filed SEP 23 1929 19.. HARRISON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Palpation

(Signed) H. E. Lentz, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Sept 23, 1929

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 3224 Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARBLE RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

E 49472

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49472

CERTIFICATE OF DEATH

40

1—PLACE OF DEATH St Joseph Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Orleans ST. (WARD) 1876

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Ringold

(a) RESIDENCE NO. 910 W Franklin ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colad	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Mathias Ringgold

6 DATE OF BIRTH (month, day, and year) Sept. 1 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
85 yrs.		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas. Brickhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary ?.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mathias Ringgold

(Address) 910 W. Franklin St

Filed SEP 23 1929 Registrar HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/29

17 I HEREBY CERTIFY, That I attended deceased from 9-13-29, 19..., to 9-20-29 19..., that I last saw h.. alive on 9-20-29, 19..., and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Pelvic Inflammatory disease (Gonorrheal origin) & Peritonitis

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-14-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) N B Handley M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 23 1929
20 UNDERTAKER	ADDRESS
Mrs. Kate R. Williams	322 Schroeder St

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49473

45 E 49473

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2535 Hollins St ST., WARD) 70-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Stephens

(a) RESIDENCE NO. 2535 Hollins St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 1 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthonia A. Stephens

6 DATE OF BIRTH (month, day, and year) August 12, 189[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward J. Stephens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore. Md.

12 MAIDEN NAME OF MOTHER Anna M& Berryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore. Md.

14 Informant Mrs Anthonia A. Stephens

(Address) 2535 Hollins St.

15 Filed SEP 23 1929, 19[illegible] G. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 24, 19 27, to Sept 21. 19 29

that I last saw him alive on Sept 21. 19 29

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1929

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. G. Murr, M. D.

9.23. 1929 (Address) 176 Callaton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Sept 24 1929

20 UNDERTAKER John J. Cowan & Son

ADDRESS 901 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49474

E 49474

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eli J Perry

(a) RESIDENCE NO. 1200 Valley ST., 10-14 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if foreign birth? 53 yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 11/15/57

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Anna Stubbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 23 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-29

17 I HEREBY CERTIFY, That I attended deceased from 9-11, 1929, to 9-22, 1929, that I last saw him alive on 9-22, 1929 and that death occurred, on the date stated above, at 2:55 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Pulmonary edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis Senile(?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 20 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H C Smith, M. D.

9/22, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Sept. 24 1929

20 UNDERTAKER Henry Heuck Sons Inc. ADDRESS 1201 E Eager St

HENRY JONES, M.

IMPORTANT; MUST BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49475

1—PLACE OF DEATH

CERTIFICATE OF DEATH

90

E 49475

REGISTERED NO.

CITY OF BALTIMORE: (No. 1537 N. Patterson Park Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul M. Koontz

(a) RESIDENCE NO. 1537 N. Patterson Park Ave ST., 16 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helen A. Koontz

6 DATE OF BIRTH (month, day, and year) Feb. 18 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 032

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City Fire dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Jacob Koontz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Anna Kisling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Helen A. Koontz

(Address) 1537 N. Patterson Park Ave.

15 Filed Oct 23 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 23 1929

17

I HEREBY CERTIFY, That I attended deceased from July 3, 1928, to Sept 23, 1929,

that I last saw h[illegible] alive on Sept 22 50, 1929

and that death occurred, on the date stated above, at 3.50 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms 9/23

(Signed) Frank H. Ogden, M. D.

9/23, 1929 (Address) 115 N. Casey St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Sept 26 1929
20 UNDERTAKER	ADDRESS
Henry A. Koch Sons, Inc	130 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 49476

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002 E 49476

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division ST., WARD) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jackson

(a) RESIDENCE NO. 214-B.O. Brunswick Md. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible] 1885

7 AGE: Years 44; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel

(c) Name of employer: Company

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Annie Jackson (Address): Ashland Va

15 Filed [illegible], 19 29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-19-1929

17

I HEREBY CERTIFY, That I attended deceased from 9-17-1929, to 9-19-1929.

that I last saw him alive on 9-19-1929.

and that death occurred, on the date stated above, at 8:35 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Peritonitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/18/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. T. Jackson M. D.

(Address) Boonsboro Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashland Va — DATE OF BURIAL: Sept 23 1929

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1925 Ashland Va

P. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49477

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 N. Fulton Ave., ST., WARD)

2—FULL NAME Dieudonnee Louise VanS.deC. Power

(a) RESIDENCE NO. 307 N. Fulton Ave., ST., 19-21 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of E.J.V. Powers

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	11	15	16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Indies

PARENTS

10 NAME OF FATHER Van Scholkwzck de Courelle

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies Isles

12 MAIDEN NAME OF MOTHER Louise French

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Indies Isles

14 Informant Adele Theresa Carroll

(Address) 307 N. Fulton Ave.,

15 C. HAMPSON JONES, M. D. Registrar

P 2 3 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 19 29, to Sept. 21, 19 29, that I last saw h alive on Sept. 21, 19 29 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 6 Yrs.

Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw Mendelsen, M. D.

9/23, 1929 (Address) 24 W. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery

DATE OF BURIAL 9/25 19 29

20 UNDERTAKER Geo. Fenley & Finley

ADDRESS Fulton & Fayette Sts.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 49478

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49478

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3710 Springdale Ave. (ST.) (WARD) 15-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugo Pradit

(a) RESIDENCE NO. 3710 Springdale Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24, 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
70	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tobacconist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Pracht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Mathes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia Pracht
(Address) 3710 Springdale

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9—22—1929

17 I HEREBY CERTIFY, That I attended deceased from 9-20—1929 to 9-22—1929 that I last saw h... alive on 9-22—1929 and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis.
(duration) Several yrs. mos ds.

CONTRIBUTORY (Secondary) Asthma.
(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Averitt Lorell M. D.

(Address) 3705 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Sept 24 1929

20 UNDERTAKER George J Smith — ADDRESS 193 Hollins

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 49479 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49479

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital St. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Schneider

(a) RESIDENCE NO. East Canton, Ohio St. 11-24 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 25 ds. How long in U. S., if of foreign birth? 57 yrs. 11 mos. 19 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Elizabeth Miller 1850

6 DATE OF BIRTH (month, day, and year) Oct. 3, ~~1849~~ 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
78	79	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country) Germany

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Germany

14 Informant Hospital records.
(Address)

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D.
By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Sept 22, 1929, that I last saw him alive on Sept 22, 1929, and that death occurred, on the date stated above, at 340 P.m.

The CAUSE OF DEATH* was as follows:

Chronic cardiovascular renal disease (chronic myocarditis; arteriosclerosis)
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation
(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Canton, Ohio — DATE OF BURIAL Sept 23, 1929

20 UNDERTAKER E. LeRoy Stiffler, Inc. — ADDRESS 125 E. North Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 49480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

x 154 ✓ E 49480

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Gaylord

(a) RESIDENCE NO. Orlando, Fla. ST., WARD Wide

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-5-1899.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Author

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Conn.

PARENTS

10 NAME OF FATHER: Andrew Gaylord

11 BIRTHPLACE OF FATHER (city or town) (State or country): Conn.

12 MAIDEN NAME OF MOTHER: Katharine Cuma

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conn.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 23 1929, 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 22, 1929, that I last saw h.. alive on Sept 21, 1929 and that death occurred, on the date stated above, at 8:35 p.m.

The CAUSE OF DEATH* was as follows:

Scleroderma

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cachexia and vomiting

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 29, 29 Sept 16, 29

Was there an autopsy? Yes Signoidostomy

What test confirmed diagnosis?

(Signed) Fred W. Keil, M. D.

9/23 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Conn

DATE OF BURIAL: Sept 24 1929

20 UNDERTAKER: Henry Heuken's Sons

ADDRESS: Orland Fla

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should indicate OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49481

CERTIFICATE OF DEATH.

129 E 49481

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 Allendale ST. 16-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr Herman A. Born

(Residence in Baltimore: No. 625 Allendale St.; Life mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 13 (Day), 1865 (Year)

7-AGE, 64 yrs. 3 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Veterinarian
(b) General nature of industry, business, or establishment in which employed (or employer) 056

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Herman Born

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth Lischer

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia S. Born

(Address) 3405 Copley Rd.

15-

Filed ..... 191.... C. HAMPSON JONES, M. D. Registrar.

SEP 23 1929 By

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 22 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7th 1927, to Sept 22nd 1929, that I saw h[illegible] alive on Sept 22nd 1929, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Calcinic Cystitis

(Duration) 8 yrs. 22 mos. ds.

(Signed) E. H. Thumm M. D.

Sept. 22, 1929 (Address) 539 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept. 25, 1929

20-UNDERTAKER Geo W Little — ADDRESS 2700 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 49482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 49482

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3603 Malden Ave ST., 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Gulden.

(a) RESIDENCE NO. 3603 Malden Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David L. A. Gulden.

6 DATE OF BIRTH (month, day, and year) May 3 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Daniel Baker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary A. Hollingsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant David L. A. Gulden.

(Address) 3603 Malden Ave.

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929, to Sept 21, 1929, that I last saw h[illegible] alive on Sept 21, 1929, and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Nature

(Signed) C. H. Gudemann M. D.

(Address) 850 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — DATE OF BURIAL Sept 24 1929

20 UNDERTAKER Chenoweth & Son — ADDRESS 3615 Chestnut Ave

EP 23 1929

INK—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49483

100-001

E 49483

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3500 Chestnut Ave ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Henry Shetla

(a) RESIDENCE NO. 3500 Chestnut Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A. Shetla

6 DATE OF BIRTH (month, day, and year) Sept 9 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Mer.

(b) General nature of industry, business, or establishment in which employed (or employer) 645

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berlin Germany

PARENTS

10 NAME OF FATHER Georg Shetla

11 BIRTHPLACE OF FATHER (city or town) (State or country) Berlin Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Elizabeth A Shetla

(Address) 3500 Chestnut Ave

15 Filed ... 1929 C. HAMPSON JONES, M. D. Registrar

EP 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 22, 1929 that I last saw h[illegible] alive on Sept 21, 1929 and that death occurred, on the date stated above, at 2.55 a. m.

The CAUSE OF DEATH* was as follows:

Bronchs pneumonia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Bronchs pneumonia

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) WS Tublet, M. D.

9/22/29 (Address) 222 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 24 1929
20 UNDERTAKER	ADDRESS
Chenowith Son	3500 Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 49484

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 28 E. Hamburg St. St., 23-33 Ward)

2-FULL NAME John C. Holler.

(a) RESIDENCE NO. 28 E. Hamburg St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married

5a If married, ~~Widowed, or Divorced~~ HUSBAND of (~~or WIFE of~~) Amanda Holler.

6 DATE OF BIRTH (month, day, and year) May 18, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cam maker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

886

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Confad Holler.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Amanda Holler. (wife)
(Address) 28 E. Hamburg St.

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D., Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 21, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to R.I.P. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of the stomach and Rectum.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto W. Leimandt, M. D.

9/28, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Cemetery, Stemmers Run	Sept 24 1929
UNDERTAKER Margaret L. Flynn	ADDRESS 1422 Light St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-002

E 49485

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 Tunbridge Road ST., 27-48 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ray Crawford Power

(a) RESIDENCE NO. 623 Tunbridge Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. -- mos. -- ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawson Vann

6 DATE OF BIRTH (month, day, and year) Dec. 1, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertising

(b) General nature of industry, business, or establishment in which employed (or employer) Manager 08

(c) Name of employer Manufacturers Record Pub. Co.

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Power

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Kate Crawford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Mr. Victor H. Power

(Address) Washington Apartments

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 27/1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Sept 27, 1929, that I last saw him alive on Sept. 27, 1929 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Patrick M. D.

9/23. 1929 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 9/24 19 29

20 UNDERTAKER Henry B. Mears & Son

ADDRESS 804 W. Calvert

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49486

CERTIFICATE OF DEATH

49 E 49486

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agatha's Hospital 4-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Shultz

(a) RESIDENCE NO. 1216 Wilkins Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-1857

7 AGE Years 72 Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Printer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Balser Froemmy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Friedman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm G. Billgrave

(Address) 131 Williamson

15 Filed SEP 23 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-29

17 I HEREBY CERTIFY, That I attended deceased from 9-10, 1929, to 9-22, 1929, that I last saw h[illegible] alive on 9-22, 1929, and that death occurred, on the date stated above, at 3:25 A.M. m.

The CAUSE OF DEATH* was as follows:

General carcinomatosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) Dr H. B Hendrix, M. D.

, 19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 9/24 19 29

UNDERTAKER F. Vahey Sons

ADDRESS 1318 Light

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Thomas S. Ford

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49487

74-0 U1

E 49487

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3407 Lake Montebello Drive St. 9-45 Ward)

2-FULL NAME Thomas S. Ford

(a) RESIDENCE NO. 3407 Lake Montebello Drive St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret B. Ford

6 DATE OF BIRTH (month, day, and year) Oct 26/1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	64	10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) 007
(c) Name of employer Penna. R.R.

9 BIRTHPLACE (city or town) Pittsburg, Pa.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Y. Ford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Deems

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Margaret B. Ford
(Address) 3407 Lake Montebello Drive

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

EP 23 1929 By Wint

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 21-29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) History Arteriosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Cain, M. D.

9-22-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem.	Sept 24 1929
20 UNDERTAKER	ADDRESS
Wm. C. Block	927 N. Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49488 185 E 49488

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Meiz

(a) RESIDENCE NO. 200 E Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) March 19, 1853

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	66	96	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown
(State or country) U.S.

PARENTS

10 NAME OF FATHER H.B. Meiz

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Vermont

12 MAIDEN NAME OF MOTHER Alvira Stanley

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Vermont

14 Informant Hugo Runde

(Address) Balto City Hosp. M. D.

15 Filed SEP 23 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-29

17 I HEREBY CERTIFY, That I attended deceased from 8-30-, 1929, to 9-22, 1929, that I last saw him alive on 9-22-, 1929 and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Fracture neck of rt femur

(duration) — yrs. — mos. 23 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) Fred M. Dunkwall, M. D.

, 19 (Address) Balto. City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	9/23 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49489

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Dr Nicholson ✓ 23rd Place
129 Lafayette Ave 1920

E 49489

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1429 W. Fayette ST., 14-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ada C. Bussey

(a) RESIDENCE NO. 1429 W Fayette ST., WARD
(Usual place of abode) (If non-resident give rity or town and State)

Length of residence in rity or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Bussey

6 DATE OF BIRTH (month, day, and year) Dec 10 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or rountry) Penna

PARENTS

10 NAME OF FATHER Adam Ruhl

11 BIRTHPLACE OF FATHER (city or town) (State or rountry) Penna

12 MAIDEN NAME OF MOTHER Marie Calhoun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs. M. Miller

(Address) 1429 W. Fayette St

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to Sept 23, 1929

that I last saw h[illegible] alive on Sept 23, 1929

and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

arterio sclerosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease rontrarted if not at plarc of death? —

Did an operation prerede death? — Date of

Was there an autopsy? Yes Clinical Lab

What test ronfirmed diagnosis?

(Signed) H. G. Nicholson, M. D.

19 29, (Address) 2230 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lehnerburg Penna	Sept 25 1929
UNDERTAKER	ADDRESS
Wm Cook	121 N Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be PROMPT in filing CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 49490

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49490

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Homestead ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest F. Panetti

(a) RESIDENCE NO. 616 Homestead ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Panetti

6 DATE OF BIRTH (month, day, and year) Sept 7-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	0	15.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supervisor

(b) General nature of industry, business, or establishment in which employed (or employer) 156

(c) Name of employer Stauffers Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ernest F Panetti.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J. Milton Panetti.
(Address) Chelsea N. C.

15 Filed SEP 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Sept 22, 1929, that I last saw h[illegible] alive on Sept 21, 1929 and that death occurred, on the date stated above, at 4 am m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.
Mitral Regurgitation (Decompensated
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Mitral Regurgitation
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None

(Signed) Chas. F. A. Simms, M. D.
9-23, 1929 (Address) 2878 Stafford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 9/24 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Baltimore St

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Runcate

E 49491 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49491

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1745 E. Lonvale ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Wermuth

(a) RESIDENCE NO. 1745 E Lonvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb 22, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Button sewer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sam Bubbock 056

9 BIRTHPLACE (city or town) (State or country) Bath Me

PARENTS

10 NAME OF FATHER John Wermuth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A Wermuth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bath Me

14 Informant Mary Wermuth (Address) 1745 E Lonvale St

15 Filed SEP 23 1929, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1. 1929 to Sept 22 1929 that I last saw h alive on Sept 22 1929 and that death occurred, on the date stated above, at 1:20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Secondary Hypertension
Cardiac Decompensation

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Lan

DATE OF BURIAL Sept 25 1929

20 UNDERTAKER W M Cook

ADDRESS 1217 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49492

CERTIFICATE OF DEATH.

E 49492

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Police State Aid Rd. St., ___ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie E. Griffith

(a) RESIDENCE NO. Washington Blvd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. do. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1st 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Umbrella Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Ganns

9 BIRTHPLACE (city or town)

(State or country) Detroit Mich.

PARENTS

10 NAME OF FATHER Henry Groth

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Michigan

12 MAIDEN NAME OF MOTHER Elizabeth Schemm

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Catherine Warren

(Address) 5805 Belair Rd Wash D.C.

SEP 23 1929 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercular Disease

of Heart

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

(Signed) (Coroner) M. D.

9/23, 1929 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the state yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwarz Cemetery Balto Md — Date of Burial: Sept 25 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St. Paul St

Spec.—1-12-23—M&T—500 Bks.

E 49493 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 E 49493

1-PLACE OF DEATH

CITY OF BALTIMORE: No. Provident Hospital 17-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Shepherd

(a) RESIDENCE No. 675 W Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

6 DATE OF BIRTH (month, day and year) Oct 6-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Rudolph Shepherd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant father

(Address)

15 Filed SEP 24 1929, 19 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929, to Sept 22 1929

that I last saw him alive on Sept 22, 1929

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? undetermined

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy.

(Signed) George McDonald, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9-24 1929
20 UNDERTAKER Daniel Easton	ADDRESS 911 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49494

CERTIFICATE OF DEATH

74001

E 49494

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 4-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Upshure

(a) RESIDENCE NO. 403 Tyson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Tarlton Upshure

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed SEP 24 1929 C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1929, to Sept. 20, 1929, that I last saw him alive on Sept. 20, 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum.

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) Marvin W. Williams, M. D.

9-20, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9-24, 1929
20 UNDERTAKER	ADDRESS
Daniel Eckert	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49495

38 E 49495

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST., 629 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Butler

(a) RESIDENCE NO. 405 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Bath Tub Factory

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Amanda Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed SEP 24 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-20-29

17 I HEREBY CERTIFY, That I attended deceased from 4-15, 1929, to 9-20, 1929, that I last saw h[illegible] alive on 9-20, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

" Aorta & insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic Focal

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. Path. Exam.

(Signed) Marvin M. H. Leas M. D.

9-22, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodberry Cemetery — DATE OF BURIAL Sept 24 1929

20 UNDERTAKER Edward Bryon — ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49496

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-001 E 49496

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home and Infirmary ST., 11-15 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Birdie Wardlaw

(a) RESIDENCE No. 1001 St. Paul ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) September 4, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. C. Wardlaw 3rd.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Ednabelle Raine Sept. 23, 1929

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Georgia

14 Informant Father
(Address)

Filed SEP 24 1929 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 23 1929

17 I HEREBY CERTIFY, That I attended deceased from September 7, 1929, to September 23, 1929, that I last saw her alive on September 23, 1929, and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute toxemia newborn
Premature

CONTRIBUTORY (Secondary) Prematurity (duration) yrs. mos 12 ds.

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas F. Daniels M. D.

(Address) 1011 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Atlanta Georgia — DATE OF BURIAL Sept 24 1929

20 UNDERTAKER Wm. Cook — ADDRESS 1217 N. Paul St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49497

CERTIFICATE OF DEATH

90 E 49497

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 14-20 Ward)

2-FULL NAME Emma E. Downs

(a) RESIDENCE NO. 1711 Druid Hill St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Col	Widowed.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Geo. Downs

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Clayton

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Georgianna Jefferson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Ernest L. Brooks
(Address) 1711 Druid Hill

15 Filed SEP 24 1929 H. HANSON JONES, M. D. Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1711 Druid Hill

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) [illegible] M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	9/25/1929

20 UNDERTAKER Wm. Geo. E. Hollan ADDRESS 1163 Druid Hill

Spec. 2-29-28—I. F. S.—500 Blks.

229079
E 49498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-002

E 49498
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Drankwicz

(a) RESIDENCE NO. 1612 Eastern Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-17-28

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Francis Drankwicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eva Wenerski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 24 1929 19 H. Hasson Jones, Registrar M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Sept 23, 1929, that I last saw h.. alive on Sept 23, 1929 and that death occurred, on the date stated above, at 11.02 P m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool Culture

(Signed) J. C. Goodwin, M. D.

9/24, 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	9/25 1929

20 UNDERTAKER Wm. Fiaskowski ADDRESS 1618 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Missing

#49499

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49500

CERTIFICATE OF DEATH

188-10 E 4950

REGISTERED NO.....

(If death occurr... a hospital or instit... give its NAME in... of street and nu... and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph's Hospital St., 10-14 Ward)

2-FULL NAME Lucien J. O'Connor

(a) RESIDENCE NO. 1231 Greenmount Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred About 78 yrs. – mos. – ds. How long in U. S., if of foreign birth? – yrs. – mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ----- 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	78	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Joseph O'Connor

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John O'Connor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Fergus O'Connor
(Address) 7 E. Franklin St.

15 Filed SEP 24 1929 19 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull
Struck from down by a
while crossing street at
unknown (duration) mos.
Central Ave

CONTRIBUTORY (Secondary)
(duration) yrs.

18 Where was disease contracted if not at place of death? Greenmount

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Coroner

(Signed) [illegible]

9/24/29 (Address) 2934 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violence state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Cathedral Cemetery

DAT... 9/...

ADD...

20 UNDERTAKER
Henry U. Myers & Son

If DEATH in plain terms, so that it may be properly classified. Blanks must be filled out. Information important. See instructions on back of certificate.

E 49501 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 49501

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Gold ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Saulsbury

(a) RESIDENCE NO. 607 Gold ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eli Saulsbery

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Thomas Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Ann Butaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co Md

14 Informant: Mamie Brown

(Address) 607 Gold St

15 SEP 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Sept 21, 1929, that I last saw her alive on Sept 20, 1929, and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Williams Tull, M. D.

Sept 21, 1929 (Address) 921 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Sept 23 1929

UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Pressman St

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49502

CERTIFICATE OF DEATH

E 49502

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE (No.) South Baltimore General Hospital (ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irene Pope

(a) RESIDENCE NO. 1410 Harlem Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER Lew Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Dodi Brown

(Address) 1410 Harlem ave

15 Filed 9-23, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21-29

17 I HEREBY CERTIFY, That I attended deceased from 9-12, 1929, to 9-21, 1929

that I last saw her alive on 9-21, 1929

and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Pulmonary Oedema
Broncho-Pneumonia

(duration) 11h. mos. 4 da.

CONTRIBUTORY (Secondary) Chronic P. t. D

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/13/29

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Joseph McCaitis, M. D.

, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Augusta Ga.	9-24 1929
20 UNDERTAKER Round Easters	ADDRESS 916 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49503

REGISTERED NO. 129

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 623 Dolphin ST., 17-24 WARD)

2—FULL NAME Thomas Floyd

(a) RESIDENCE NO. 623 Dolphin ST., WARD
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Francis Floyd

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	0	0	6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Ship Yard

(c) Name of employer: Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Henry Floyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Peggy Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. Francis Floyd
(Address) 623 Dolphin St

15 Filed: SEP 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 22, 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Sept 22 1929 that I last saw h live on Sept 21, 1929 and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH was as follows:

Mitral Stenosis & Nephritis
(or Medical Consultants)

(duration) — 4 — mos. +

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if ~~not~~ at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam Test

(Signed) H Stewart, M. D.

9/23/1929 (Address) 704 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Va	9-24 1929
20 UNDERTAKER: Dennis Easton	ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49504 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 49504

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 S. Conkling ST. 36-37 WARD)

REGISTERED NO. E 49504

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Rutter

(a) RESIDENCE NO. 1108 S. Conkling ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert H. Rutter

6 DATE OF BIRTH (month, day, and year) Jan. 27-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George W. Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary A. Reps

(Address) 1108 S. Conklin St.

15 Filed SEP 24 1929 CLAMPITT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22-1929

17 I HEREBY CERTIFY, That I attended deceased from June 15th., 1929, to Sept 22., 1929.

that I last saw her alive on Sept 21 ult., 1929

and that death occurred, on the date stated above, at 2.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) From History about 5 yrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Analysis (Urine)

(Signed) David W. Jones, M. D.

9/23/1929 (Address) 1011 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Sept 25 1929
20 UNDERTAKER	ADDRESS
George W. Zibler	737 E. Eager st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49505

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 E. Biddle ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Louise Hackney

(a) RESIDENCE NO. 1601 E. Biddle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R. Hackney

6 DATE OF BIRTH (month, day, and year) Aug. 8-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Peter Epron.

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Nancy Carback

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant John R. Hackney

(Address) 1601 E. Biddle St.

15 SEP 24 1929 E. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22. 1929. to Sept. 22. 1929. that I last saw h[illegible] alive on " " 1929 and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy - Hemorrhagic

4 hrs. 15 minutes
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephretis and high blood pressure (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

9/23/1929 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Sept. 25 1929
20. UNDERTAKER	ADDRESS
George W. Zirkelbach	1737 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49506

CERTIFICATE OF DEATH

31

E 49506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 N. Gilmor ST. 19-27 WARD)

2—FULL NAME Cathrenine Reid

(a) RESIDENCE NO. 206 N. Gilmor ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, 1906

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Windsor Heights Md.

PARENTS

10 NAME OF FATHER Jacob Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary L. Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Reid

(Address) 206 N. Gilmor St

15 Filed SEP 24 1929 [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to Septl 21, 1929 that I last saw her alive on Sept. 21, 1929 and that death occurred, on the date stated above, at 8:35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. White, M. D.

19 (Address) 1021 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 24, 1929
20 UNDERTAKER	ADDRESS
Mrs. Kate R. Williams	3227 Schroeder St

Spec.—8-16-29—L. F. S.—100 Bks.

Smith ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49507

CERTIFICATE OF DEATH

9 E 49507

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 S 32d ST., 26-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Jane Smith

(a) RESIDENCE NO. 921 S 32d ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12 1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Lester Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary I Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lester I Smith

(Address) 921 S 32d St

15 Filed SEP 24 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Sept 23, 1929, that I last saw h[illegible] alive on Sept 23, 1929 and that death occurred, on the date stated above, at 3 33 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. H. Long, M. D.

9-23, 1929 (Address) 2711 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Sept 25 1929
20 UNDERTAKER	ADDRESS
Heath Mem Co	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 49508

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3521 Leaverton Ave ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie E. Corbin

(a) RESIDENCE NO. 3521 Leaverton ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Corbin

6 DATE OF BIRTH (month, day, and year): Dec 20 1872

7 AGE — Years: 56 — Months: 9 — Days: 3 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Harvelle

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Charles Corbin

(Address): 3425 Leaverton Ave

15 Filed SEP 24 1929 G. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 23 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/15-29. 19 , to 9-23-29 19 , that I last saw h[illegible] alive on 9/23-29 and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder

(duration) yrs. 6. mos. ds.

CONTRIBUTORY (Secondary) Chronic Pharinchy. Neg Arthritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Wirmann M. D.

9/15/29 (Address) 2913 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem

DATE OF BURIAL: Sept 26 29

20 UNDERTAKER: John Weiss

ADDRESS: 2008 Albon

GIK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49509
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

× 90 E 49509
REGISTERED NO.

CITY OF BALTIMORE: (No. 314 N Carey ST. 19-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Schadt

(a) RESIDENCE No. 314 N Carey ST., ... WARD Lowell Mass
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Justus Schadt

6 DATE OF BIRTH (month, day, and year) Aug 25 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 37
(b) General nature of industry, business, or establishment in which employed (or employer) 07
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lowell Mass

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Justus Schadt
(Address) 314 N Carey

15 Filed SEP 24 1929 . 19 C. HERBERT JONES, M. D. Registrar
By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10 . 1929 . to Sept 24 . 1929 .
that I last saw her alive on Sept 23 . 1929
and that death occurred, on the date stated above, at 1.05 A m.
The CAUSE OF DEATH* was as follows:

General Anasarca

(duration) yrs. 4 mos — ds.
CONTRIBUTORY (Secondary) Aortic Vascular
(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Gustus F Robinson M. D.
. 19 (Address) 456 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Bc.	Sept 25 1929
UNDERTAKER W M Routson	ADDRESS 2334 Pr St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 185 E 49510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hosp St., 25-72 Ward)

2-FULL NAME Warren Henry

(a) RESIDENCE NO. Alberton, Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1/ 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1917

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	12			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Robert Henry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Ella Henry

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Robert Henry
(Address) Alberton Md

15 Filed ....., 19.... C. HAMPSON JONES, Registrar

SEP 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry)
find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Ruptured spleen, fell from roof of house while painting

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Thompson M. D.

9/26, 19 29 (Address) 3601

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alberton Md — DATE OF BURIAL 9-25 19

20 UNDERTAKER H. C. Hyde Walthan St Elkridge — ADDRESS

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49511

CERTIFICATE OF DEATH.

161-001 ✓

E 49511

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 5719 Pimlico Rd (Ward) 27-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME unnamed infant boy Henry & Mabel Graham

(a) RESIDENCE NO. 5719 Pimlico Rd St. 27 Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. min ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep. 23/29

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or 10 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore City

PARENTS

10 NAME OF FATHER Henry B. Graham

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore City Md

12 MAIDEN NAME OF MOTHER Fesher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore City Md

14 Informant Henry B. Graham

(Address) 5719 Pimlico Road

15 Filed 19 Registrar

D 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1929, to Sept 23, 1929

that I last saw her alive on Sept. 23, 1929

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows: Prematurity 7th month gestation. Labor residing from Prolapse uterus.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same as above

(duration) yrs. mos. ds.

Is Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. R. Wantz, M. D.

9/23 1929 (Address) 2601 Manhattan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: SINAI HOSPITAL Date of Burial 9/24/1929

20 UNDERTAKER or Health Dept. ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 49512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 49512

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) President Hospital ST. 11-24 WARD)

2-FULL NAME Geraldine Thomas

(a) RESIDENCE NO. 1213 Druid Hill Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Lloyd Thomas

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/10 1929, to 9/16 1929, that I last saw her alive on 9/16 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Pulmonary T.B.C.

Independent (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pelvic Peritonitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R Peters M. D.

9/17, 1929 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL SEP 19 1929

20 UNDERTAKER [illegible] CEMETERY. 19

ADDRESS [illegible] E WOODAL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

EP 24 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 49513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 49513

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3313 Beech Ave ST., 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Hannon Lipscomb

(a) RESIDENCE NO. 3313 Beech Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Jan 12 29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Wm T. Lipscomb

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Annie E Hannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Wm. T. Lipscomb

(Address) 3313 Beech Ave

15 Filed SEP 24 1929 C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Sept 24, 1929

that I last saw h. alive on Sept 23, 1929

and that death occurred, on the date stated above, at 12.40 a. m.

The CAUSE OF DEATH* was as follows:

Enteric - Colitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Campbell M. D.

Sept 24, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 25 1929
20 UNDERTAKER	ADDRESS
Thanner & Son	2615 Edmondson Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49514

89 E 49514

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1509 John St., 14-20 Ward)

2-FULL NAME Walter C. Thatcher

(a) RESIDENCE NO. 1509 John St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Hattie B Thatcher

6 DATE OF BIRTH (month, day and year) Sept 8-1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75		14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Jesse R Thatcher

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Matilda Daniels

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Caroline B Thatcher
(Address) 1509 John St

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

Per _____

EP 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 22nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H Ehrlich M. D.

Sept 22nd (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 25 1929
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Bath St

Spec.—2-Z9-28—L. F. S.—500 Bks.

E 49515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49515

1—PLACE OF DEATH

REGISTERED NO. 1927

CITY OF BALTIMORE: (No. 325 N. Stricker St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pricilla Brooks

(a) RESIDENCE NO. 325 N. Stricker St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widow

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lewis Brooks

6 DATE OF BIRTH (month, day, and year) L 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	54	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cavert Co. Md.

PARENTS

10 NAME OF FATHER Daniel Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Bessie (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co.

14 Informant Octavia Torney

(Address) 325 N. Stricker

15 Filed SEP 24 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 21st. '29

17

I HEREBY CERTIFY, That I attended deceased from April 1st. 29 to Sept. 21. 19 29

that I last saw h ed alive on Sept. 19th. 19 29

and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Ins.

Abt. Year (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hem.

3 days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 , (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emerson Calvert Co. Md

UNDERTAKER Mrs. Katie R. Williams

DATE OF BURIAL Sept 25, 29

ADDRESS 3221 Edmondson Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be specific. Every item of information should be stated EXACTLY. PHYSICIANS should be specific. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

(Brickhouse)

E 49516. HEALTH DEPARTMENT—CITY OF BALTIMORE

146 E 49516

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 11-15

CITY OF BALTIMORE: (No. 33rd & Calvert ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Brickhouse

(a) RESIDENCE NO. 14 E Madison ST., Balto WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31, 1908

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Casualty Co.

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James L. Brickhouse

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Alma Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant The Deceased

(Address)

15 Filed SEP 24 1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23/29

17 I HEREBY CERTIFY, That I attended deceased from 9/18/29, 1929, to 9/23/, 1929, that I last saw h[illegible] alive on 9/23, 1929 and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Streptococcus Hemolyticus

(Signed) [illegible] M. D.

9/23, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Md.	Sept. 25 1929

20 UNDERTAKER Wm Carter ADDRESS 1217 St. Paul

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 49517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86-E 49517

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2537 W. Balto St., 20-64 WARD)

2-FULL NAME Walter E. Middleton

(a) RESIDENCE NO. 2537 W. Balto ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20th 1913

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
16	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto - Md

10 NAME OF FATHER Robert S. Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rosanna E. M. Rampley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mary E. Middleton.
(Address) 2537 W. Balto St

15 Filed SEP 24 1929 19. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 19 29 to Sept 22, 19 29 that I last saw h alive on Sept 21, 19 29 and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sudden death urine positive

(Signed) C Lee Adams M. D.

9/27 19 29 (Address) 2105-A Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cem. | DATE OF BURIAL: Sept 25 19 29

20 UNDERTAKER: C. S. Nugent | ADDRESS: 1852 W. Balto St

U. S.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49518

CERTIFICATE OF DEATH.

160 E 49518

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Cottage

CITY OF BALTIMORE: (No. 3631 Coolidge ave. ST. 15-58 WARD)

2-FULL NAME Norman C Lewis

(a) RESIDENCE No. 3631 Coolidge ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14-1929

7 AGE — Years — Months — Days 10 — If LESS than 1 day, hrs. or min. 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Loyd L. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Emmalee R. Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore County.

14 Informant: Anna J. Russell (Address) 3631 Coolidge ave.

15 Filed SEP 25 1929 H. HANCOCK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/17 . 1929 . to 9/14 . 1929. that I last saw him alive on Sep. 23 . 1929.. and that death occurred, on the date stated above, at 7:30a m.

The CAUSE OF DEATH* was as follows:

1 Uremia 2 Diabetes

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of.

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Herman L. Klopp M. D.

, 19 (Address) 836 Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — DATE OF BURIAL 9/26 1929

20 UNDERTAKER: Tenge & Early — ADDRESS Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49519 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49519

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Walker.

(a) RESIDENCE NO. Havre de Grace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helen Walker

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Richard Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Minnie Greer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 25 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 24 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1929, to Sept. 24, 1929, that I last saw h alive on September 24, 1929 and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bronchus

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Havre de Grace

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Havre de Grace Md.	9-25 1929
UNDERTAKER J. G. Pennington & Son	ADDRESS Havre de Grace Md.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. ANGELINE. BYGSYNSKA

E 49520

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 49520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland ST., 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angeline Bygesynska

(a) RESIDENCE NO. 808 S. Eleven ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 18-1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto City

10 NAME OF FATHER Stanislaus Bygesynska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Stella Barbulski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 INFORMANT James Stanislaus Bygesynski

(Address) 808 S. Eleven St

15 Filed SEP 25 1929, 19 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23 1929

17

I HEREBY CERTIFY, That I attended deceased from 9-13, 19 29, to 9-23, 19 29,

that I last saw h alive on 9-23, 19 29,

and that death occurred, on the date stated above, at 7.00 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus Amputation

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B J Cohen, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Sept 27 29
20 UNDERTAKER Stephen J Frankowski Inc.	ADDRESS Kenwood 1003 Ave

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 49521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49521

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Louis Kuhl

(Residence in Baltimore: No. 1907 N. Monroe St. St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced (write the word.) Married

6-DATE OF BIRTH. January (Month) 3 (Day) 85 (Year)

7-AGE. 73 yrs. 8 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired Oil
(b) General nature of industry, business, or establishment in which employed (or employer) Produce Business

9-BIRTHPLACE, (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER. Frederick Kuhl

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Justina Schulz

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ena Kuhl

(Address) 1907 N. Monroe St.

15-

Filed SEP 25 1929 HAMPSON JONES, M. D. Registrar.

Per ELH

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. September (Month) 23 (Day) 1929 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Eugene Miller M. D.
(Coroner)

Sept 25 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. 9/26/29

20-UNDERTAKER. Wm. J. Buckner & Sons ADDRESS. N. Gay St.

Filed SEP 25 1929

H. JONES, M. D. Registrar.

Per ELH

H.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

George Gross

E 49522 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 49522

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 15203

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Gross

(a) RESIDENCE NO. 1311 Woodyear st. ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 SEP 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1929, to Sept. 22, 1929, that I last saw him alive on Sept. 22, 1929 and that death occurred, on the date stated above, at 10.05 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) [signature] M. D.

9-22, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn [illegible] DATE OF BURIAL Sept 25 29

B. UNDERTAKER [illegible] ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

~~E 29327~~
~~E 49523~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 49523

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Crowder

(a) RESIDENCE NO. 1042 Shark ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-2-27

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Josie Owen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 25 1929 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-23-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept-22, 1929, to Sept 23, 1929, that I last saw h.... alive on Sept 23, 1929 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Meningitis (Pneumococcic)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. G. Goodwin, M. D.

9/24, 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct

DATE OF BURIAL Sept-25 1929

20 UNDERTAKER J. L. Brumbaugh

ADDRESS 1018 W Fay 9st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49524

CERTIFICATE OF DEATH.

E 49524

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home for Aged St. Lapsley WARD)

2-FULL NAME Mary Frank

(a) RESIDENCE NO. 2944 Eastern Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jerome Frank

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Riga Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Sigel (daughter) (Address) 1944 Eastern Ave

15 Filed SEP 25 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1929, to Sept. 24, 1929, that I last saw her alive on Sept. 24, 1929, and that death occurred, on the date stated above, at 1 0 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Cerebral Thrombosis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) Milton Sherry M. D.

9/27, 19 29 (Address) 9 W. St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Memorial Park

DATE OF BURIAL 9/25 19 29

UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-1001

E 49525
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2702 Whitney ave St. 27-55 Ward)

2-FULL NAME Harry P. Farr

(a) RESIDENCE NO 2702 Whitney ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Eliz. S. Farr

6 DATE OF BIRTH (month, day and year) Nov. 13. 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63	10	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Y. W.
(c) Name of employer

9 BIRTHPLACE (city or town) Chicago
(State or country) Ill.

PARENTS

10 NAME OF FATHER Geo. Farr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ill.

12 MAIDEN NAME OF MOTHER Augusta Lovell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Vermont

14 Informant Eliz. S. Farr
(Address) 2702 Whitney ave

Filed SEP 25 1929 HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 2432 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Sept. 26 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell Sons	1900 Eutaw pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49526

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Lakeland – 2700 Hoffman St., Ward) Frog Rd

2-FULL NAME Louis R. Frank

(a) RESIDENCE NO. 2410 Brohawn St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug - 24 - 29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	10		29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Wm A Frank

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Russell

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Wm. A Frank.
(Address) 2410 Brohawn St

15 Filed SEP 26 1929 By C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
Knocked down by auto while running across street after
pony dropped Ruptured Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Contusion Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hollins Ferry Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) 9/25 1929 L. J. Frame M. D.

(Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetary — DATE OF BURIAL Sept 26 1929

20 UNDERTAKER C. Schloman & Son — ADDRESS 1039 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49527

CERTIFICATE OF DEATH

90 V E 49527

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917-N-Calvert ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Christopher Fawcett

(a) RESIDENCE NO. 2917-N-Calvert ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 11 ds. How long in U. S., If foreign birth 71 yrs. 7 mos 11 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora L. Fawcett

6 DATE OF BIRTH (month, day, and year): Feb 13/1858

7 AGE — Years: 71 — Months: 7 — Days: 11 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Banker

(b) General nature of industry, business, or establishment in which employed (or employer): Retired from

(c) Name of employer: Garrett & Son

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Christopher Fawcett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Maud Stephenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belfast Ireland

14 Informant: Mrs Margaret E Fawcett

(Address) 4215 Pinkney Ave

15 FILED SEP 25 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24/1929

17 I HEREBY CERTIFY, That I attended deceased from May 1 1924 to Sept 24 1929 that I last saw him alive on Sept 24 1929 and that death occurred, on the date stated above, at about 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Chronic
Acute dilatation heart

(duration) yrs. 10 mos. Missed

CONTRIBUTORY (Secondary) Dead when Dr reached house

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) J J Hurley, M. D.

9/25, 19 29 (Address) 110 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Sept 28 1929
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49528

CERTIFICATE OF DEATH

74-001

E 49528

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 Club Road ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Goldsborough Zimmerman

(a) RESIDENCE NO. 302 Club Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 83 yrs. 2 mos. 29 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. S. Zimmerman

6 DATE OF BIRTH (month, day, and year) June-25-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Talbott Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Marlin Goldsborough

11 BIRTHPLACE OF FATHER (city or town) Talbott Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Hayward

13 BIRTHPLACE OF MOTHER (city or town) Talbott Co
(State or country) Maryland.

14 Informant Frank S. Zimmerman - (Son)
(Address) 116 St Johns Roads.

15 Filed SEP 25 1929 H. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-23-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept-12, 1929 to Sept-23, 1929, that I last saw h e alive on Sept-23, 1929 and that death occurred, on the date stated above, at 10-10 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia due to Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Senile Arteriosclerosis (duration) yrs. 11 mos. ds.

(duration) 3 + yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) M. Gibson Boyer, M. D.

9/24, 1929 (Address) 4822 Roland Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Sept 25 1929.
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 90

E 49529

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Maryland Av ST., 12-20 WARD)

2—FULL NAME Ella Catherine Fort

(a) RESIDENCE NO. 2023 Maryland Av. ST., WARD Franklintown R. Rd.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 0 ds. How long in U. S., if foreign birth? 87 yrs. 9 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Leander D. Fort.

6 DATE OF BIRTH (month, day, and year) Dec-20-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in whirh employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John D. Curlis

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Richstein

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs Ella C. McComas (daughter)
(Address) 2126 St Paul St. City

15 Filed SEP 25 1929, 19 HAMPSON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24-1929

17

I HEREBY CERTIFY, That I attended deceased from August 15, 19 29, to Sept 24, 19 29, that I last saw h[illegible] alive on Sept 24, 19 29 and that death occurred, on the date stated above, at 2:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) [illegible] M. D.

9/24, 1929 (Address) 2112 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sep. 26, 19 29

20 UNDERTAKER Stewart Memorial Co ADDRESS Balto.

IMPORTANT: Answer all questions as carefully supplied. Any inaccuracy in this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49530

CERTIFICATE OF DEATH

185 E 49530

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah Cunningham

(a) RESIDENCE NO. 1025 Wilcox ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	~~Unknown~~ Widow

5a If married, widowed or divorced (or) WIFE of ~~HUSBAND~~ of Saml. D. Cunningham ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) ~~Unknown~~ 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER James McWilliams

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed SEP 25 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 30, 19 28 to Sept. 22, 19 29

that I last saw her alive on Sept. 22, 19 29

and that death occurred, on the date stated above, at 9:35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Hypertension.

Exposure ? (duration) ? yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home & Car

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Obs. & X-Ray

(Signed) Marvin M. McLean M. D.

9-23, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	9/25/1929

20 UNDERTAKER E. O. Fanning Wm - 1938 E. Lafayette Ave

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49531

CERTIFICATE OF DEATH

43 E 49531

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. Arlington Ave. WARD)

REGISTERED NO. 48-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James T. Pearl

(a) RESIDENCE NO. 19 S Arlington ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-8-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer) B & O.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Lillie Rehling
(Address) 2539 S. Arlington Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25. 29

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1928, to Sept 25, 1929, that I last saw h[illegible] alive on Sept 24, 1929 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tonsil

about (duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Laboratory

(Signed) Simon Cooke M. D.

, 19 (Address) 120 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 27 19 29

20 UNDERTAKER John O. Mitchell Sons ADDRESS Class Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88-103 V

E 49532

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hos St. 76-36 Ward)

2-FULL NAME George L. Anderson

(a) RESIDENCE NO. Camp Holabird Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Aug-18-1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34	1	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Army
(c) Name of employer

9 BIRTHPLACE (city or town) Georgetown
(State or country) Tenn

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mrs Roy Watkins Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Tenn

14 Informant U.S. Army Records
(Address) Camp Holabird

P 25 1929

C. HAMPSON JONES, M.D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by truck
auto in which he was a ride
Side striped another

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Holabird Md
or Camp Holabird
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) F. J. Frame M. D.

9/23. 1929 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cleveland Tenn — DATE OF BURIAL Sept 25 1929

20 UNDERTAKER Sol Levinson Bro — ADDRESS 1127 E Balto St

R.—WRITE PLAINLY, WITH UNFADING INK—This is A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS' should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49533

CERTIFICATE OF DEATH.

E 49533

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Penitentiary St. 1115 Ward) Shadwell

2-FULL NAME Peter Dowld alias Thos. Enright alias Harry Bat alias Peter Oates

(a) RESIDENCE NO. Md. Penitentiary St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 2-8-1913

7 AGE: Years 16 Months 7 Days 6 (27?) IF LESS than 1 day ..... hrs. ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boy

(b) General nature of industry, business, or establishment in which employed (or employer): Driver

(c) Name of employer

9 BIRTHPLACE (city or town): Md (?)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Police Dept.

(Address)

15 Filed ..... 19 ..... Registrar

P 25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 25th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

Suffering with Mental depression

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

Sept 25 1929 (Signed) W. C. Fahy M. D.

(Coroner)

(Address) 1039 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial Sept 25 1929

20 UNDERTAKER: E. V. Fanning ADDRESS: Inc-1986 Lafayette Ave.

C. HAMPSON JONES, M. D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 49534

1—PLACE OF DEATH Majestic Apts.

CITY OF BALTIMORE: (No. 910 Brooks Lane ST., 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophie Oppenheimer May.

(a) RESIDENCE NO. Majestic Apts. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 76 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis May.

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Hanson Oppenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Babbette ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Miss. Edna May

(Address) Majestic Apt.

15 Filed C. HAMPSON JONES, M. D., 19

P 25 1929 By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept, 19 29 to Sept 24, 19 29.

that I last saw h alive on Sept 24, 19 29

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteio-sclerosis - diabetes

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) anemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lentz, M. D.

9-25, 1929 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shaw Friendship Cem.	9/26/1929
20 UNDERTAKER	ADDRESS
Harris Sonnenborn	118-25 W. 21st. Royal Ave.

OF DEATH in plain terms, so that it may be properly c... important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49535

CERTIFICATE OF DEATH

90 E 49535

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2654 Edmondson Ave (St.) 16-69 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Perlatz

(a) RESIDENCE NO. 2654 Edmondson Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1847

7 AGE: Years 82 Months 7 Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Soldier Retired

(b) General nature of industry, business, or establishment in which employed (or employer): U. S. A.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town): "

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): "

(State or country): Unknown

14 Informant: Mrs Tucker

(Address) 2654 Edmondson Ave

15 Filed SEP 25 1929 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1929 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 19 29 to Sept 25 19 29

that I last saw him alive on Sept 25 19 29

and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of prostate

Electro Dessication

(duration) yrs. 8 mos da.

CONTRIBUTORY (Secondary) Cerebral Paresis

Impending Gangrene (duration) yrs. mos 2 da.

18 Where was disease contracted

if not at place of death? At Home

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Earle W Brown, M. D.

19 (Address) 806 N Milton Ave E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL— Edmondson Cem. Date of Burial Sept 27 19 29

20 UNDERTAKER H. H. Little

ADDRESS 5124 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100, Bks.

E 49536 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49536

CERTIFICATE OF DEATH

161-01

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 117 S Broadway WARD) 2-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Philip A Restivo

(a) RESIDENCE NO. 117 S Broadway WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Philip Restivo

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Rosetta Genovese

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant 117 S Broadway
(Address)

15 Filed SEP 25 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23 1929 to Sept 25 1929

that I last saw him alive on Sept 25 1929

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia 7 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malaria Eclampsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Sept 26 1929 Jos. L. Voltaggio M. D.
(Signed)
, 19 (Address) 14 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 28 1929
20 UNDERTAKER	ADDRESS
M. F. E. Dufendach	37 Lamb

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49537

CERTIFICATE OF DEATH

X 16 E 49537

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Calvert & 33rd ST.) 12-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dolores R Krueger

(a) RESIDENCE NO. Catonsville Heights ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	3	3	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Heights Md.

PARENTS

10 NAME OF FATHER Charles Kruger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna G. Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant V. Kruger

(Address) Catonsville Heights Md.

15 Filed SEP 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Sept 25, 1929 that I last saw h.er alive on Sept 25, 1929 and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 2 wks. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Catonsville Heights Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wallace Swartzwelder, M. D.

. 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept 28 1929
20 UNDERTAKER	ADDRESS
H. L. Kephart	115 N. Calvert St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49538

CERTIFICATE OF DEATH

114 E 49538

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 Ashton ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Fullerton

(a) RESIDENCE NO. 221 Ashton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 22nd 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm O. Fullerton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Virginia Sewell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. O. Fullerton (Address) 221 Ashton St.

15 9 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25-29.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1929, to Sept. 24, 1929, that I last saw him alive on Sept. 23, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W B Baumgardner M. D.

9/25, 1929 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Sept. 27, 19 29
20 UNDERTAKER	ADDRESS
J. R. Pindell & Son	1800 E. Pratt St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-1029—A Co.—100 Bks.

I Rakes

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 49539

CERTIFICATE OF DEATH

1984 ✓

E 49539

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Raker

(a) RESIDENCE NO. 23 N. Amity St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col'd	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	—	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto No

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant
(Address) 423 N. Fulton Ave

15 Filed , 19 C. HAMPSON JONES, M. D.
Registrar

EP 261929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage Left Lung
from Stabbed wound (Homicide)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooks M. D.

Sept 24. 1927 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 26 1927
20 UNDERTAKER	ADDRESS
Daniel Carbon	Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-20-28—L. F. S.—500 Blks.

2E 90S-2
2E 49540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9√ E 49540

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Whitehead

(a) RESIDENCE NO. 1715 Riggs Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/26/28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Herbert Whitehead

11 BIRTHPLACE OF FATHER (city or town) Pa —
(State or country)

12 MAIDEN NAME OF MOTHER Hilda Ford

13 BIRTHPLACE OF MOTHER (city or town) Md —
(State or country)

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 26 1929 H. LEE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-24-29

17

I HEREBY CERTIFY, That I attended deceased from Sept- 13, 1929, to Sept- 24, 1929, that I last saw him alive on Sept- 24, 1929 and that death occurred, on the date stated above, at 9 25 a. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Goodwin, M. D.

9/24, 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9-26 1929
20 UNDERTAKER	ADDRESS
Samuel Carton	916 Pa ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49541

CERTIFICATE OF DEATH.

101-201

E 49541

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Sapp ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Williams

(a) RESIDENCE NO. 503 Sapp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed 1862

6 DATE OF BIRTH (month, day, and year) [redacted]

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 020

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Preston Campbell

(Address) 1922 Eutaw ave

15 Filed SEP 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1929 to Sept 24 1929.

that I last saw h[illegible] alive on Sept 24 1929

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Auto Lobar Pneumonia

(duration) yrs mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? none

What test confirmed diagnosis? typical

(Signed) [illegible] M. D.

19 (Address) 608 Lemmon st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	sept 27 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(6) HENDON JOHNS, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 49542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Aisquith Street ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Pulcheria Mary Cahill

(a) RESIDENCE No. School Sisters of Notre Dame ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~July~~ 20, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
69 Years		2 months	4 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 065

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Cahill

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Gallagher. 9/25. 1929

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant School Sisters of Notre Dame
(Address)

Filed SEP 26 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 24, Sept 1929

17 I HEREBY CERTIFY, That I attended deceased from September 24, 1929, to September 24, 1929, that I last saw her alive on September 24, 1929, and that death occurred, on the date stated above, at 1.25 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 3 6hrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Convent in Annapolis Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) F. Finley, M. D.

(Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Md.	Sept 27 1929
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

William E. Thawley

E 49543

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49543

90 V

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Appold M.E. Church Chase & Washington Sts St., 8-13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Thawley

(a) RESIDENCE NO. 1213 N. Durham St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19/1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sexton
(b) General nature of industry, business, or establishment in which employed (or employer) Appold M.E. Church
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Talbott Co., Md.

PARENTS

10 NAME OF FATHER Wm. E. Thawley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Molly Greenley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Wm. Thawley
(Address) 4300 LaSalle Ave

15 Filed SEP 26 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cor. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

9/25/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Sept. 27 1929
20 UNDERTAKER Henry Houck Funeral	ADDRESS 1301 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49544

CERTIFICATE OF DEATH.

74-001

E 49544

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 N charles ST. 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion Elizabeth Bourdeau

(Residence in Baltimore: No 1315 N. Charles St.; 16 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-~~SINGLE, MARRIED, WIDOWED, or DIVORCED.~~ (Write the word.) Widowed

6-DATE OF BIRTH. May (Month) 11th (Day), 1842 (Year)

7-AGE. 87 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer). at home

9-BIRTHPLACE. (State or Country). Bakersfield Vt

PARENTS.

10-NAME OF FATHER. John Saffy

11-BIRTHPLACE OF FATHER (State or Country). England

12-MAIDEN NAME OF MOTHER Mary Roberts

13-BIRTHPLACE OF MOTHER (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daughter

(Address) 1315 N Charles

15-

Filed.....191.... H. M. JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September (Month) 24 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1929. to Sept 24 1929. that I saw her alive on Sept 24 1929. and that death occurred, on the date stated above, at 12.45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Artio Sclerosis

(Duration) yrs. mos. ds.

(Signed) Flora Pallack M. D.

Sept 24 1929 (Address) 1110 N Eutaw St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. Sept 27, 1929

20-UNDERTAKER Wm McCarter ADDRESS 2217 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

C 49545 HEALTH DEPARTMENT—CITY OF BALTIMORE 29 E 19545

19545

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A. Miller Jr.

(a) RESIDENCE NO. 4316 E Fontral ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mall	White	Singl.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John A. Miller

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Dorothy Williams

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Maryland

14 Informant Hospital Record.
(Address) Balto. City Hosp.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-29

17 I HEREBY CERTIFY, That I attended deceased from 9-23-29, 19, to 9-24-, 1929, that I last saw him alive on 9-24-, 19, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute tetanus

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumococcus septicemia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Fred M. Dunkenell, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL 9/27 1929

20 UNDERTAKER Wm Cook. — ADDRESS 1210 E Pratt St

SEP 28 1929 S. S. HAMPSON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49546

CERTIFICATE OF DEATH

129

E 49546

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Parker Lewis

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 4 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Jan 4. 1853

7 AGE	Years	Months	Days	11 LESS than 1 day, ... hrs. or ... min.
	76	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Andrew B. Lewis

11 BIRTHPLACE OF FATHER (city or town) Baltimore.
(State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Shemwick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mt Hope Retreat
(Address) Mt Hope Retreat

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1924, to Sept 25, 1929, that I last saw h alive on Sept 24, 1929 and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Arterio-Sclerosis)

Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Dementia

— (duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? By Physician

What test confirmed diagnosis?

(Signed) Mullen P. Hill M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	9/27 19 29
20 UNDERTAKER J. Wm Cook	ADDRESS 127 E. Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49547

CERTIFICATE OF DEATH.

129 E 49547

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital, Baltimore, Md. St. 27 WARD 43)

2-FULL NAME Frederick J. Assing

(a) RESIDENCE NO. 3104 Woodhome Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Assing

6 DATE OF BIRTH (month, day, and year) March 13, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Third Mate

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Dora Weems

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Assing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotta Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

15 Filed SEP 26 1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 19 29

17

I HEREBY CERTIFY, That I attended deceased from September 12, 19 29, to September 25, 19 29,

that I last saw him alive on September 25, 19 29,

and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & clinical findings

(Signed) Ralph L. Porter M. D.

9/25/29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edel Hill

UNDERTAKER H. M. Cook

DATE OF BURIAL 9/27 19 29

ADDRESS 1217 E. Pratt St

mation should be carefully supplied. PAGE 2 should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH fully and clearly, so that if necessary it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49548

CERTIFICATE OF DEATH

74001 E 49548

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1426 S. Charles ST. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaretta Weber

(a) RESIDENCE NO. 1240 Wall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Weber

6 DATE OF BIRTH (month, day, and year) Dec 23 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma E. Hammond

(Address) Ridgely, Md.

15 Filed ..... 19 ..... H. HANSON JONES, M. D. Registrar

SEP 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20. 19 29 to Sept 24. 19 29

that I last saw her alive on Sept 24. 19 29

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. H. Campbell M. D.

Sept 25 19 29 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, Brkyn

DATE OF BURIAL 9/27 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Bruce
105 Charles Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92

1—PLACE OF DEATH E 49549 REGISTERED NO. E 49549

CITY OF BALTIMORE: (No. 216 E. 22nd ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lowell H. Gladding

(a) RESIDENCE NO. 216 E. 22nd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia E. Gladding

6 DATE OF BIRTH (month, day, and year) Nov 26 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	69 70	9.	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer R. E. Company

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Julia Gladding
(Address) 216 E 22nd Street

15 Filed SEP 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 25, 1929 that I last saw him alive on Sept 9, 1929 and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History, Symptoms

(Signed) Jno. H. Buxton M. D.

Sept 25 1929 (Address) 2105 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 28 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49550

CERTIFICATE OF DEATH.

90 E 49550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 W Saratoga ST. 18-16 WARD)

2-FULL NAME Charles Bryant

(a) RESIDENCE NO. 936 W Saratoga ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Gertrude Bryant

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Gertrude Bryant (Address) 936 W. Saratoga St

15 Filed SEP 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-1929

17

I HEREBY CERTIFY, That I attended deceased from 8-19-, 1929, to 9-22, 1929, that I last saw h[illegible] alive on 9-19-, 1929 and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. L. Jackson M. D.

9/27/29 (Address) 600 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL 9/26 1929

20 UNDERTAKER Mrs Kate R. Williams — ADDRESS 322 [illegible] St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 49551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 49551

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Lying-in Hosp. 18-26 Ward)

2-FULL NAME Herbert E Hurt.

(a) RESIDENCE NO. 316 N. Arlington Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) July 29-1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		2	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Hurst.

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Lola Johnson

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Harry Hurst
(Address) 316 N. Arlington Ave.

15 Filed SEP 26 1929 J. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Smith M. D.
Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Sept 26, 1929
20 UNDERTAKER Mrs Katie R. Williams & Edwards	ADDRESS 312

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49552

118-002

E 49552

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1225 McCulloh St. 11-24 Ward)

2-FULL NAME Reese Skipley

(a) RESIDENCE NO. 1225 McCulloh St.. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Gertrude Skipley

6 DATE OF BIRTH (month, day and year): 1871

7 AGE: Years 58 | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Solicitor 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Leonard Johnson
(Address) 1225 McCulloh

15 Filed SEP 26 1929 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 25 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) ... M. D.

Sept 25 19 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: McCulburn — DATE OF BURIAL: 9/27 1929

20 UNDERTAKER: Samuel McClure & Son — ADDRESS: Hor Rd

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 29234
E 49553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 90 ✓

E 49553 REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William T Walston

(a) RESIDENCE NO. Stantonsburg N. Car ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie

6 DATE OF BIRTH (month, day, and year) 11-12-84

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N Car

PARENTS

10 NAME OF FATHER Turner Walston

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car

12 MAIDEN NAME OF MOTHER Mollie Robins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 26 1929 19 [illegible] Registrar

EP 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Sept 26, 1929, that I last saw h.m alive on Sept 26, 1929 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and hypertension

Myocardial insufficiency,

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? North Carolina

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Hedwig Koenig, M. D.

9/26, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilson N C	9/26/1929
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Reverdy

Important. See instructions on back of certificates. Property classified. Exact statement of OCCUPATION is very

Spec.—1-12-23—M&T—500 Bks.

E 49554

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49554

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1350 N Fremont Ave WARD)

REGISTERED NO. 11-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lanie Johnson

(a) RESIDENCE NO. 1350 N Fremont Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Johnson

6 DATE OF BIRTH (month, day, and year) Jan 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER John Epps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Daughter

(Address) 2429 Druid Hill Ave

Filed SEP 26 1929 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 6th 1929 to Sept 25 1929.

that I last saw him alive on Sept 25 1929

and that death occurred, on the date stated above, at 10:45 pm.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) General Debility

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 1350 N Fremont Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Ernest Thurston, M. D.

, 19 (Address) 2129 Pa. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Sept 28 1929

UNDERTAKER Clarence E Wright

ADDRESS 1964 Mary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49555

89

1—PLACE OF DEATH

REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. 103 Park Lane ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Adt

(a) RESIDENCE NO. 103 Park Lane ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert W. Adt

6 DATE OF BIRTH (month, day, and year) August 27, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	-	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Von Mitzel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Frey

13 BIRTHPLACE OF MOTHER (city or town) Germantown
(State or country) Pennsylvania

14 Informant Mr. Albert W. Adt

(Address) 103 Park Lane, Roland Park

15 Filed SEP 26 1929 THOMPSON JONES, M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to Sept. 25, 1929, that I last saw her alive on Sept - 24, 1929 and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart, especially right side - Angina Pectoris 1921 and 1924. Cardiac failure with General Edema (duration) yrs. 4 mos. 11 ds.

CONTRIBUTORY (Secondary) Essential Hypertension (duration) 8 yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs -

(Signed) M. Gibson Porter, M. D.

9/25. 1929 (Address) 4822 Roland Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Sept. 27 1929
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 West Baltimore St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49556

CERTIFICATE OF DEATH

90 E 49556

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 235 N. Lafayette ave 11-24 (Ward)

2-FULL NAME Rev. Frank M. Gibson

(a) RESIDENCE NO. 235 N. Lafayette ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Plummer Gibson

6 DATE OF BIRTH (month, day and year) Jany 16. 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	72	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clergyman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Penna
(State or country)

PARENTS

10 NAME OF FATHER Alex. E. Gibson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Markey

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary T. Gibson
(Address) 235 N. Lafayette ave

15 Filed SEP 26 1929 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Sept 24 19 29 (Address) Coroner M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 26 1929
UNDERTAKER	ADDRESS
J. O. Mitchell	Govans Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Barnard.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49557

CERTIFICATE OF DEATH

129 ✓ E 49557

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3925 Frisby St. ST., 9-47 WARD)

2—FULL NAME Morgorette Boden Barnard

(a) RESIDENCE NO. 3925 Frisby St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed or divorced BUSBAND of (or) WIFE of John R Barnard

6 DATE OF BIRTH (month, day, and year) Sept 14/55

7 AGE	Years	Months	Days 10	If LESS than 1 day, hrs. or min.
	74	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ot Home

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Geo. W. Deal

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A Boden

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant J Edward Deal

(Address) 3937 Lowndes Ave

15 Filed 9 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept. 24/29

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st, 19 29, to Sept 24th 19 29, that I last saw her alive on Sept 23rd, 19 29 and that death occurred, on the date stated above, at 4.20 a m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Geo Yungeberg III M. D.

9/27, 19 29 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	9/27/29

20 UNDERTAKER George J Roth ADDRESS 1735 Hanover

Per

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49558

CERTIFICATE OF DEATH

90 V

E 49558

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm H. Boone

(a) RESIDENCE NO. 1121 E. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 Date SEP 26 1929 G. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24-29

17 I HEREBY CERTIFY, That I attended deceased from 9-23, 1929, to 9-24, 1929, that I last saw him alive on 9-24, 1929 and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis, Chronic Fatal

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? P.C. Lab. Findings

(Signed) Warren H. Phelps, M. D.

9-26, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Sept. 28 1929

20 UNDERTAKER Wm. R. Johnson & Co. ADDRESS 710 N. Caroline St.

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49559

168 E 49559

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2042 E. Eager St., 7-13 Ward)

2-FULL NAME Henry or Andrew Szczublewski

(a) RESIDENCE NO. 2042 E. Eager St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. - mos. - ds. How long in U. S., if of foreign birth? 32 yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Agnes Szczublewski

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	about 70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Gas Co
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER ? Szczublewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Vincent Zaleski
(Address) 2042 E. Eager St

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 25/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation-Hung himself in bed noon.
(Suicide)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos. Pollitt, M. D.

9-26-29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.	Sept. 28. 1929.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 2315 Eastern Ave

P 26 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49560

CERTIFICATE OF DEATH

E 49560

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Lacy

(a) RESIDENCE NO. 1514 Clement ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	white	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Frank Lacy

6 DATE OF BIRTH (month, day, and year): June 3. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Wm. allender

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Mary Wickton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: ~~Mrs~~ Miss Ruth Lacy

(Address): 1514 E. Clement St.

15 Filed ... 19 ... C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 24/29

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1929. to Sept 24. 1929.

That I last saw her alive on Sept 24, 1929

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rt. Cheek

(duration) 2 5 yrs mos. da.

CONTRIBUTORY (Secondary): Fractured Left femur

(duration) yrs 2 mos. 16 da.

18 Where was disease contracted if not at place of death? —

(over)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) Arthur Rathbun, M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Sept. 27 1929
20 UNDERTAKER: Margaret D. Flynn	ADDRESS: 1422 Light St.

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 49561 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital — REGISTERED NO. 90

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves (St.) 28-63 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Prudentia Gaitley

(a) RESIDENCE NO. St. Agnes Hospital St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) (C) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
84				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister of Charity 065

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt Savage Md

PARENTS

10 NAME OF FATHER Patrick Gaitley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Galway Ireland

12 MAIDEN NAME OF MOTHER Bridget Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister Mary Clare.
(Address) St Agnes Hospital

15 Filed 2 6 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24 1929

17 I HEREBY CERTIFY, That I attended deceased from July 19th, 1927, to Sept 24th, 1929, that I last saw her alive on 9-24, 1929 and that death occurred, on the date stated above, at 11 40 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Geo P Glenn M. D.

Sept 25 1929 (Address) 1504 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 9-27-1929

20 UNDERTAKER Martin Fahey Sons — ADDRESS 121 W Mount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49562 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49562

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4408 Falls Road ST. 27-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Aquilla Wheeler.

(a) RESIDENCE NO. 4408 Falls Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Wheeler.

6 DATE OF BIRTH (month, day, and year) Dec 14, 1849.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Thomas Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Angeline Moffitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Elizabeth Wheeler.

(Address) 4408 Falls Road.

15 Filed SEP 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25, 1929.

17 I HEREBY CERTIFY, That I attended deceased from March, 19 25, to Sept 25, 19 29, that I last saw h~~im~~ alive on Sept 25, 19 29 and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hubert Thompson, M. D.

Sept 26, 1929 (Address) 146 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden	Sept 28 1929.

20 UNDERTAKER Schnorrenberg Son. ADDRESS 745 Cathedral

Property examined. Exact statement of OCCUPATION necessary
important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 49563

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49563

CERTIFICATE OF DEATH.

74-001

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1510 N. Gilmor St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Wright

(a) Residence No. 402 Wilson St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph

6-DATE OF BIRTH (month, day and year) ? 1881

7-AGE. 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer). Home

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, David Wilson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), S. C.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Joseph Wright

(Address) 402 Wilson St

15- Filed 2 6 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-24-29

17- I HEREBY CERTIFY, That I attended deceased from 9-14- 1929 to 9-24- 1929.

that I last saw h.er alive on 9-24- 1929

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 10 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Lawrence M. D.

. 19 (Address) 1232 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	9/27/ 29
20-UNDERTAKER.	ADDRESS
Wm. Geo. H. Holland	1631 Druid Hill

in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49564

CERTIFICATE OF DEATH

47

E 49564

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Rose Maciach

(a) RESIDENCE NO. 1401 Decatur ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Maciach

6 DATE OF BIRTH (month, day, and year) June 15 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Adam Bongard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Maciach Husband
(Address) 1401 Decatur St

15 Filed ....., 19.... C. HAMPSON JONES, M. D.
Per ..... Registrar

26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1929, to Sept 24 1929, that I last saw h.. alive on Sept 24, 1929, and that death occurred, on the date stated above, at 3 25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the lung - secondary to Carcinoma of Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W B Kundrat, M. D.

, 19 (Address) 1 South Hoyard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Sept 28 1929
20 UNDERTAKER	ADDRESS
John H Weber	400 S Chester St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49565

CERTIFICATE OF DEATH

100-001

E 49565

REGISTERED NO. 64835

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Lewandowski

(a) RESIDENCE NO. 1446 Hull St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6 1909

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Loading ships

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Stanley Lewandowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Clementine Zambrzyiski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

11 Informant Wanda Lewandowski

(Address) 1446 Hull St.

15 Oct 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26-1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Sept 26, 1929, that I last saw h.. alive on Sept. 26, 1929, and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Pleurisy & Effusion (Left.)

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin sympt. Phy Exam Lab. findings

(Signed) H. Glenn Spatchett, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 30 1929
20 UNDERTAKER	ADDRESS
John M Weber	410 E Chestnut

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 49566

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 16-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr William Donohue

(a) RESIDENCE NO. Belair Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. 6 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 015

9 BIRTHPLACE (city or town) (State or country) Ashland Pa.

PARENTS

10 NAME OF FATHER Bryan Donohue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs M. Cardiff (Address) 638 E. Mahanoby Ave

15 Filed P 2 6 1929, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-24 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-18, 19 29. to 9-24, 19 29.

that I last saw him alive on 9-24, 19 29

and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

(1) Generalized arterio sclerosis

(2) Embolus to brain with hemiplegia

(3) Embolus to R brachial artery with gangrene of R hand (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 23

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ardmore Pa. DATE OF BURIAL Sept 28 1929

20 UNDERTAKER John C. Miller ADDRESS 1135 E Alyn

IMPORTANT—Before filling out this certificate, read carefully the instructions on back of certificate. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49567 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49567

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. 6-9 ST., WARD)

2-FULL NAME Walter Harwood Myers

(a) RESIDENCE No. 576 West Annapolis Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Feby 7 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Walter H. Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Eliza Dorgue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md.

14 Informant Walter H Myers

(Address) Annapolis Md

15 Filed SEP 26 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1929, to Sept. 26, 1929, that I last saw h alive on Sept 26, 1929 and that death occurred, on the date stated above, at 4:20 m.

The CAUSE OF DEATH* was as follows:

Fracture 5th cervical vertebra

(Over)

(duration) yrs. mos 3 3 ds.

CONTRIBUTORY (Secondary) asphyxiation from

numerous blows (duration) yrs. mos. 6-7 min. ds.

18 Where was disease contracted if not at place of death? Calvert County Md

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Et. only

(Signed) Dr Frank J Hurst, M. D.

Sept 26 1929 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md

DATE OF BURIAL Sept 26 1929

20 UNDERTAKER Jos S. Taylor Sons

ADDRESS Annapolis

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49568

CERTIFICATE OF DEATH

114 E 49568

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosps St., 17-24 Ward)

2-FULL NAME Jas. Williams

(a) RESIDENCE NO. 806 Druid Hill St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Williams

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Fortuneak
(State or country) S. C.

PARENTS

10 NAME OF FATHER Warren Williams

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Mary Williams
(Address) 806 Druid Hill

Filed SEP 27 1929 S. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Ulcers of Intestines

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) H. Blank, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Sept 27, 29

20 UNDERTAKER John N. Toadvine — ADDRESS 1021 Druid Hill

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

49569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓ E 49569

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 725 W. Fayette St. 4-16 Ward)

2-FULL NAME Elton Chamberlain

(a) RESIDENCE NO. 725 W. Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single (?)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Buffalo N.Y.

PARENTS

10 NAME OF FATHER — Chamberlain

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. P. McGovern
(Address) 600 W. Biddle St

Filed SEP 27 1929 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Kilby M. D.

9/27. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C.A. Co	Sept 27, 1929
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E

49570 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

77 E 49570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 Penrose ave ST. 70-69 WARD)

2-FULL NAME James E Simone

(a) RESIDENCE NO. 2204 Penrose ave ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V Simone

6 DATE OF BIRTH (month, day, and year) March 8-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Simone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Leon Brooks

(Address) 17 Scallon St

15 Filed SEP 27 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 7, 1921, to Sept 25, 1929, that I last saw h in alive on Sept 25, 1929 and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Dorsalis Tabes

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann

(Signed) David Gruss M. D.

9/25, 1929 (Address) 1520 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL 9/28 1929

20 UNDERTAKER Robert Brooks Son — ADDRESS Calhoun Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

98 ✓

E 49571

CERTIFICATE OF DEATH

E 49571

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 28-64 ST. or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Jane Shields

(a) RESIDENCE NO. 4407 Park Liberty Heights WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 17-1929

7 AGE: Years | Months 6 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER: Albert B Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore City

12 MAIDEN NAME OF MOTHER: Maria McNulty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore City

14 Informant: Albert B Shields

(Address) 4407 Liberty Heights Ave

15 Filed SEP 27 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/26/29

17 I HEREBY CERTIFY, That I attended deceased from 9-20, 1929, to 9-26, 1929, that I last saw h[illegible] alive on 9-26, 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Laryngitis

(Culture neg for diphtheria)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-26-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyhe, M. D.

9/26 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvert — DATE OF BURIAL: Sept 28 19 29

UNDERTAKER: A. B. Marshall — ADDRESS: 353 Fallsway

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49572

CERTIFICATE OF DEATH

9° ✓ E 49572

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 813 S Robinson ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine J Fisher

(a) RESIDENCE NO. 813 S Robinson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Charles T. Fisher

6 DATE OF BIRTH (month, day, and year) Dec 2 - 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Rembold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Ling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas L Fisher

(Address) 9210 E Pratt St

15 Filed SEP 27 1929 M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25. 1929

17

I HEREBY CERTIFY, That I attended deceased from May 21st, 1929, to Sept 25, 1929

that I last saw her alive on Sept 25. 1929

and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 4 mos. 4 ds.

CONTRIBUTORY (~~Secondary~~) Iron History 2 yrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D W Jones, M. D.

9/26, 1929 (Address) 1011 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Sept 28 1929
20 UNDERTAKER John Ulrich	ADDRESS 2108 Mc Cam

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

E 49573

CERTIFICATE OF DEATH

REGISTERED NO. E 49573

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST. 20-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry James Whitworth

(a) RESIDENCE NO. 601 Cedar Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

6 DATE OF BIRTH (month, day, and year) Sept 23 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Harry J. Whitworth

11 BIRTHPLACE OF FATHER (city or town) md (State or country)

12 MAIDEN NAME OF MOTHER Virgie Wilson

13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

14 Informant Harry J. Whitworth

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1929, to Sept 26, 1929, that I last saw him alive on Sept 26, 1929, and that death occurred, on the date stated above, at 2:45 P.m.

The CAUSE OF DEATH* was as follows:

Intra cranial Hemorrhage

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? delivery

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. B. Johnson, M. D.

Sept, 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Balto Co	Sept 27 1929
20 UNDERTAKER	ADDRESS
Chenoweth Bros	2017 Eutaw

Important. See instructions on back of certificates.

SEP 27 1929 HAMDEN JONES, M.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49574 | 17 VE 49574

REGISTERED No.

E 49574
1-PLACE OF DEATH

City of Baltimore: (No. 530 Tyson St., 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Clayton

(a) RESIDENCE NO. 530 Tyson St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mo

PARENTS

10 NAME OF FATHER Wm Clayton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mo

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Margaret Carter
(Address) 427 Tyson St

15 Filed ....., 19.... Registrar

SEP 27 1929 HAROLD J. ROSE M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis due to ruptured appendix.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) August Fuller M. D.

9/26. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	9-27 1929
20 UNDERTAKER	ADDRESS
D Lamont Easton	Balto

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49575

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 49575

CITY OF BALTIMORE: (No. 223 Myrtle ave ST. 17-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hackley

(a) RESIDENCE NO. 223 Myrtle ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer gtd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Robert Hackley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lillie Gibson

(Address) 223 Myrtle ave

15 Filed SEP 27 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25-1929

17 I HEREBY CERTIFY, That I attended deceased from 9-22-, 1929, to 9-25-, 1929, that I last saw him alive on 9-25-, 1929 and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows: Terminal Bronchopneumonia

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis (duration) yrs. 4 mos. 4 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 7 ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Hamilton Jones, M. D.

9-26 1929 (Address) Eastern Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrington Va — DATE OF BURIAL 9-28-29

20 UNDERTAKER Daniel Easton — ADDRESS 216 Park ave

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 49576 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

116-601

116 E 49576

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balto. General

CITY OF BALTIMORE: (No. 14-28 ST. WARD)

2-FULL NAME Sherman Meekins

(a) RESIDENCE NO. 1515 N. Lanvale ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 24, 1892

7 AGE: Years 37 Months 7 Days 5 If LESS than 1 day, hrs. or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Eastern Shore, Md.

PARENTS

10 NAME OF FATHER: John A. Meekins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Eastern Shore, Md.

12 MAIDEN NAME OF MOTHER: Mary R. Chester

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eastern Shore Md.

14 Informant (Address): Wife West Balto Md

15 Filed SEP 27 1928 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/26, 1929

17

I HEREBY CERTIFY, That I attended deceased from 9/25, 1929, to 9/26 1929 that I last saw him alive on 9/26 1929 and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia & Gangrene, Sigmoid Colon and perforation & generalized Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Shock. 3 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/26/29.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical-Operation

(Signed) J. Vastagna, M. D.

(Address) West Balto. General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md.

DATE OF BURIAL: 9-27 1928

UNDERTAKER: David Carter

ADDRESS: 716 Aisquith

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 49577

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 657 Vine ST., 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Cohen

(a) RESIDENCE NO. 657 E. Vine ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 27, 1912

7 AGE Years 17 Months 6 Days 29 If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Carrie Denberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ethel Cohen (Address) 657 Vine St.

15 Filed SEP 27 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Septr 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Septr 26 1929 that I last saw her alive on Septr 26, 1929 and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical regular

(Signed) L. S. Hockett, M. D.

(Address) 1198 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 9-27 1929

20 UNDERTAKER Dennis Carter — ADDRESS 916 Park

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49578

CERTIFICATE OF DEATH

24-001

E 49578

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2545 Francis ST., 13-54 WARD)

2—FULL NAME Emma M. Saddler

(a) RESIDENCE NO. 2545 Francis ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

6a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of: John T. Saddler

6 DATE OF BIRTH (month, day, and year): Feby 23 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59 ~~Last~~	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Home work.

(c) Name of employer: John B. Ludwig

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Wm M. Florence

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs Hattie Spurrow

(Address): R. F. D.

15 Filed 12 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Sept 26, 1929, that I last saw her alive on Sept 25 1929 and that death occurred, on the date stated above, at 2.45 9 .m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Hypertension

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) George Abner Harden, M. D.

9/26, 1929 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Sept 28 1929
20 UNDERTAKER: Harry W. Ehlen	ADDRESS 1944 N. North Ave

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49579

CERTIFICATE OF DEATH.

7F-001

E 49579 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2731 W. North ave ST., 25-68 WARD)

2-FULL NAME Ernest Wilmot

(a) RESIDENCE No. 2731 W. North ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Post

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George H. Wilmot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Josephine Boubin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Dorris

(Address) 2731 W. North ave.

Filed SEP 27 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23rd, 1929 to Sept 25th, 1929.

that I last saw him alive on Sept 25th, 1929.

and that death occurred, on the date stated above, at 12-30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. P. Byerly, M. D.

19 (Address) 3048 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	Sept 28 1929

20 UNDERTAKER Jeremiah Jeffries

ADDRESS 1600 W. North Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Annie Kwiatkowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49580

E 49580

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2222 Cambridge St ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Kwiatkowski

(a) RESIDENCE NO. 2222 Cambridge Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Aug. 15-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Adam Kwiatkowski, Son

(Address) 416 S. Ann Street

15 Filed SEP 27 1929 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1929, to Sept 25, 1929.

that I last saw her alive on Sept 25, 1929

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Apoplectic Stroke - left side

Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lyttey, M. D.

, 19 (Address) 43 W. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery — DATE OF BURIAL: Sept/26/1929

20 UNDERTAKER: George A. Weber — ADDRESS: 705 S. Ann St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49581

CERTIFICATE OF DEATH

100 E 49581

1—PLACE OF DEATH Balto City Hospt

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST., 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Ford

(a) RESIDENCE NO. 136 E Cross St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Captain

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) Balto City Hosp.

15 Filed SEP 27 1929 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-26-29

17

I HEREBY CERTIFY, That I attended deceased from 6-13-, 1929, to 9-26, 1929

that I last saw him alive on 9-21, 1929

and that death occurred, on the date stated above, at 8 11 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis Confusional Deterioration (duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm Holmes Jones M. D.

9/26 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 30 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 49582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 49582

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Steamer City of Richmond

City of Baltimore: (No. En route from West Point Va. 23-31 Ward)

2-FULL NAME Moses Ford.(O)

(a) RESIDENCE NO. 932 S. Sharp St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
WIFE of Annie Ford.(O)

6 DATE OF BIRTH (month, day, and year) August 11, 1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman D
(b) General nature of industry, business, or establishment in which employed (or employer) Stmr. City of Richmond.
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Moses Ford.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know

14 Informant Annie Ford.(C) wife.
(Address) 932 S Sharp St.

15 Filed....., 19.. C. HAYDON JONES, M. D. Registrar
By

SEP 27 19

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 23, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What tests confirmed diagnosis? Inquiry
(Signed) Otto M Reinhardt, M. D.
9/26, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cr	Sept 28 1929
20 UNDERTAKER	ADDRESS
D. L. Brown & Son	1017 E Madison

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49583

CERTIFICATE OF DEATH

101-001

E 49583

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 709 S. Robinson St, ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jan Wojcik

(a) RESIDENCE NO. 709 S. Robinson St, ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Wojcik

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Hylary Wojcik

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Mazurek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Mary Wojcik
(Address) 709 S. Robinson St.

15 Filed SEP 27 1929 C. HAMPSON JONES, M. D. Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25. 29

17 I HEREBY CERTIFY, That I attended deceased from 9/23, 1929, to 9/24, 1929

that I last saw him alive on , 1929

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Alcoholism

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Freiberg M. D.

9/26. 1929 (Address) 1218 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sept. 28 1929
20 UNDERTAKER	ADDRESS
F. W. Ozarowski	1930 Eastern AVE

Cor.—10-10-29—A Co.—100 Bks.

E 49584 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49584

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2011 Sparks St., St., 7-4 Ward)

2-FULL NAME Anna Kalbarczyk,

(a) RESIDENCE NO. 2011 Sparks St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 13 1918

7 AGE: Years 11 | Months | Days 12 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Kalbarczyk

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Turek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant John Kalbarczyk
(Address) 2011 Sparks St

15 Filed 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) 6 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted? If not at place of death? Dr's Care

Did an operation precede death? Date of

Was there an autopsy?

What final confirmed diagnosis?

(Signed) H. C. Grady, M. D.

19 (Address) 113 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary | DATE OF BURIAL: Sept 28 1929

20 UNDERTAKER: F. W. Ozarowski | ADDRESS: 1930 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. HAMPSON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

E 49585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 E 49585

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 804-N-Calvert St., 11-15 Ward)

2-FULL NAME Harry Snowden Stabler

(a) RESIDENCE NO. 864-N-Calvert St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 64 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): About 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	about 64	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Author

(b) General nature of industry, business, or establishment in which employed (or employer): Writings

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Lynchburg

(State or country): Virginia

PARENTS

10 NAME OF FATHER: Mr. Stabler

11 BIRTHPLACE OF FATHER (city or town): Lynchburg

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Miss Owens

13 BIRTHPLACE OF MOTHER (city or town): Lynchburg

(State or country): Virginia

14 Informant: Dr. E. K. Quinn - (Friend)

(Address) 1733 Linden Ave.

15 Filed SEP 2 1929

HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above. Sept 26

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound in brain

(duration) Instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

26 (Signed) H. R. Ruby M. D.

(Coroner)

. 19 29 (Address) 1659 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 21 yrs. 0 mos. 0 ds. In the State 40 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? 804-N-Calvert St

Former or usual residence 804-N-Calvert St

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fort Lincoln Cemetery - Md. Date of Burial Sept 28 1929.

20 UNDERTAKER: Steward & Mowen Co Balto. ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 49586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9V E 49586

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST. 15 WARD)

2-FULL NAME Ida R Reese

(a) RESIDENCE No. 3018 Windsor Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm T. Reese

11 BIRTHPLACE OF FATHER (city or town) Long Green
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Barth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) maryland

14 Informant Harper Reese
(Address)

15 Filed SEP 27 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to Sept 26, 1929, that I last saw her alive on Sept 26, 1929, and that death occurred, on the date stated above, at 4 00 P m.

The CAUSE OF DEATH* was as follows:

Chronic rheumatic pancarditis

(duration) 25 yrs. mos ds.

CONTRIBUTORY (Secondary) Embolism + occlusion of L. femoral + gangrene L foot (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home (abode residence)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Hampson Jones, M.D.

, 19 (Address) 1723 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 28th 1929

20 UNDERTAKER J. Putnam Jones ADDRESS 1723 N Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49587

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49587

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 416 N. Pratt ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan Latane

(a) RESIDENCE NO. Plaza Apt. Wilsons Park Ge WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word): Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) June 19th 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	70	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Staunton Va

PARENTS

10 NAME OF FATHER: James A. Latane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Holladay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: James A. Latane

(Address): Plaza Apt

15 Filed SEP 27 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26th 29

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19 22 to Sept 1, 19 29

that I last saw her alive on Sept 1, 19 29

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis —

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Sept 26, 29 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Sept 28 1929

20 UNDERTAKER: Henry Jenkins & Son

ADDRESS: Church & Franklin Sts

Spec.—2-29-28—L. F. S.—500 Blks.

E 49588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49588

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 N. Kresson ST. 26-39 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophia Marie Wehrheim

(a) RESIDENCE NO. 917 N. Kresson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 70 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 30-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John P. Wehrheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Eh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry W. Wehrheim

(Address) 917 N. Kresson St.

15 Filed OCT 7 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Sept 25, 1929, that I last saw h[illegible] alive on Sept 25, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis Insufficiency

Senility (duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B. Lemmon M. D.

9/26, 1929 Address 917 N. Kresson Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept. 28 1929
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 49589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49589

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 939 N Dallas ST. 7-13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Elizabeth Brown

(a) RESIDENCE NO. 939 N Dallas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

a If married, widowed, or divorced (or) WIFE of Wilson Brown

6 DATE OF BIRTH (month, day, and year) about 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen —?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Josephine D. Barnett.
(Address) 939 N. Dallas St

15 Filed SEP 27 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to Sept 26, 1929, that I last saw h[illegible] alive on Sept 24, 1929 and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos.

CONTRIBUTORY (Secondary) Hypertension also myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Lab.

(Signed) R. J. Young M. D.

9/26, 1929 (Address) 1424 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Evergreen Cemetery	9-28 1929
20 UNDERTAKER	ADDRESS
Mrs C has G. Bailey	1421 Jefferson

Spec.—2-29-28—L. F. S.—500 Blks.

49590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 49590

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Josephs Hosp. ST., 8-12 WARD)

2—FULL NAME Joseph Monfalcone

(a) RESIDENCE NO. 1610 N. Patterson Park Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Christie Monfalcone.

6 DATE OF BIRTH (month, day, and year) Mar 2—1870

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 50

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Dominick Monfalcone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Christie Monfalcone

(Address) 1610 N. Patterson Park Ave

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

P 2 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/26/29

17 I HEREBY CERTIFY, That I attended deceased from 9/15/29, 19.., to 9/26/29, 19.., that I last saw him alive on 9/26/29, 19.. and that death occurred, on the date stated above, at 4:05A m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 15 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) gangrene foot

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9/25/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) A. B. Thursday, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept 29, 1929
20 UNDERTAKER	ADDRESS
Mrs C. Millet & Son	2334 Jefferson St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49591

CERTIFICATE OF DEATH

31

E 49591

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2036 Cliftwood Ave ST. E-45 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J Timm

(a) RESIDENCE NO. 2036 Cliftwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 2 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 27 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printing Dept

(b) General nature of industry, business, or establishment in which employed (or employer) McCormick Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry J. Timm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Harry J Timm

(Address) 2036 Cliftwood Ave

15 Filed 19 H. HAYWOOD JONES, M. Registrar

9 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-25th-1929

17 I HEREBY CERTIFY, That I attended deceased from July 28 19 29 to September 25 19 29

that I last saw h alive on, September 25 19 29

and that death occurred, on the date stated above, at 9 20 A M.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Cassenberg M. D.

(Address) 1375 E 10th Ave

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	9-28 1929
20 UNDERTAKER	ADDRESS
E+B Hartz	115 E West St

Spec.—1-10-21—M&T—1500 Blks.

E 49592 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49592

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1707 N Chapel ST., 23 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley B Cole

(a) RESIDENCE No. 1707 N Chapel ST., 23 WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Francis Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Emma Risser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frances Cole
(Address) 1707 N Chapel st

15 9 27 1929 G. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Sept 27, 1929, that I last saw h[illegible] alive on Sept 26, 1929, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dept R K Campbell M. D.

9-27, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Sept 28th 1929

20 UNDERTAKER E Schlosman & Son ADDRESS 1034 Hanover st

CAUSE OF DEATH to be plainly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 49593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 E 49593

1-PLACE OF DEATH

City of BALTIMORE: (No. 1316 W. Mulberry St. 19-16 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Bruce

(a) Residence No. 1316 W. Mulberry St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12½ hrs ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 25, 1929

7-AGE. ...0... yrs. ...0... mos. ..... ds.

If LESS than 1 day, 12½ hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — 900

(c) Name of employer —

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md.

PARENTS.

10-NAME OF FATHER, Henry Settle

11-BIRTHPLACE OF FATHER (city or town) Howard Co. (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Susie Bruce

13-BIRTHPLACE OF MOTHER (city or town) Howard Co. (State or Country) Maryland

11- (Informant) .....

(Address) JOHNS HOPKINS HOSPITAL

15- Filed 2 7 1929 C. HAMPSON JONES, M. D. Registrar. RPW

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 25, 1929

17- I HEREBY CERTIFY, That I attended deceased from Sept 25, 6 P.M. 1929 to Sept 25, 6:30 P.M. 1929 that I last saw her alive on Sept. 25, 8 A.M. 1929 and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Louis B. Haas M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 2x 1929

20-UNDERTAKER Health Dept ADDRESS

Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49594

CERTIFICATE OF DEATH

161-001 E 49594

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1302 W Lanvale ST. 16-23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Savage

(a) RESIDENCE NO. 1342 W Lanvale ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/24/29

7 AGE — Years — Months — Days — If LESS than 1 day 10 hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herman Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ethel Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Ethel Lee Payne

(Address) 1313 Lanvale

15 Filed SEP 27 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/24/29

17 I HEREBY CERTIFY, That I attended deceased from 9/24/29, 19, to 9/27, 19 29.

that I last saw h. alive on 9/24, 19 29

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. E. Dell, M. D.

19, (Address) 1313 Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL SEP 27 1929

20 UNDERTAKER

(Address)

Commissioner of Health.

Spec.—2-29-28—L. F. S.—500 Blks.

(? Herbert)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49595

CERTIFICATE OF DEATH

34 E 49595

1—PLACE OF DEATH

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. St Joseph's Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kenneth Herbert

(a) RESIDENCE NO. 2736 Oak ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 7-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Am Hoslery Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Co Md

PARENTS

10 NAME OF FATHER Clarence A Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Adele Mattingly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Jane Herbert

(Address) 2736 Oak St

15 Filed 2 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-26-29

17 I HEREBY CERTIFY, That I attended deceased from 9-16, 1929, to 9-26, 1929, that I last saw h[illegible] alive on 9-26-, 1929 and that death occurred, on the date stated above, at 5 45 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchiectasis & Toxaemia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) [illegible] M. D.

9/26 1929 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Sept 28 1929
20 UNDERTAKER [illegible]	ADDRESS [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

E 49596 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 49596

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 836 Parkwood (WARD) 11-24

REGISTERED NO.

2—FULL NAME Agnes Marie Jackson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 836 Parkwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 21, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Co., (State or country) Maryland

PARENTS

10 NAME OF FATHER John A. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adelaide McGlaughlin

13 BIRTHPLACE OF MOTHER (city or town) Fairfield (State or country) Pennsylvania

14 Informant Mr. Charles E. Jackson

(Address) 216 W. Madison St.

15 Date 2 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to Sept 27, 1929, that I last saw h[illegible] alive on Sept 26, 1929, and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Mediastinum to my knowledge

Left Lung (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical & X Ray

(Signed) R. L. Kirkpatrick M. D.

19 (Address) 1 Wentworth apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Sept 30 1929

20 UNDERTAKER Henry W. Meinstson

ADDRESS 805 N. Calvert St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49597

CERTIFICATE OF DEATH

91-002 E 49597

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1927 W. Saratoga ST. 70-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A. Dykes

(a) RESIDENCE NO. 1927 W. Saratoga ST., WARD

(Usual place of abode) Almost all

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary G. Dykes

6 DATE OF BIRTH (month, day, and year) March 1, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railway & Elect. Co

9 BIRTHPLACE (city or town) Oeallo

(State or country) Baltimore County, Md.

PARENTS

10 NAME OF FATHER James A. Dykes

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Rostter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Mary G. Dykes

(Address) 1927 W. Saratoga St.

15 7 1929, 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1929 to Sept 25, 1929, that I last saw h. im alive on Sept 25, 1929 and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) about 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) G. E. Dutton, M. D.

9/26, 1929 (Address) 301 E. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept. 28 19 29

20 UNDERTAKER Joseph Cook

ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 49598 81

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 Albrecht ✓ E 49598

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cornelius Albrecht

(a) RESIDENCE NO. 1637 Warwick ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-5-28

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edw. Albrecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Viola Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 2 71929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-26-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Sept 26, 1929, that I last saw him alive on Sept 26, 1929 and that death occurred, on the date stated above, at 9 35 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of spinal fluid

(Signed) Benj. E. Hodges, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	9/28 1929
20 UNDERTAKER H. M. Cook	ADDRESS 1217 E Lond St

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Whit 2800 St Paul St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49599

90 E 49599

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 N Broadway ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse R Lester

(a) RESIDENCE NO. 1115 N Broadway ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~ M

6 DATE OF BIRTH (month, day, and year): Jan 31, 1868

7 AGE: Years 61 | Months 7 | Days 25 | If LESS than 1 day, hrs. or min.

7a If married, widowed, or divorced HUSBAND of (or) WIFE of: W.W.W. Jr.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Hopewood Apts

9 BIRTHPLACE (city or town) (State or country): Westminster Md

PARENTS

10 NAME OF FATHER: John Lester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Mary Braken

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ella Lester

(Address) 1115 N Broadway

15 Filed 2 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sep 15, 19 29, to Sep 26, 19 29, that I last saw h[illegible] alive on Sep 25, 19 29 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) a Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W White Jr. M. D.

9/27. 1929 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rood Cem

DATE OF BURIAL: 9/28 19 29

20 UNDERTAKER: D. J. Cook

ADDRESS 1215 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Dickson 3055 W North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49600

CERTIFICATE OF DEATH

7+001 ✓

REGISTERED NO. E 49600

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3118 Presbury st ST. 15-67 WARD)

2—FULL NAME Isabella Rutherford

(a) RESIDENCE NO. 3118 Presbury St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm H Rutherford

6 DATE OF BIRTH (month, day, and year) May 19th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant Alex M Rutherford

(Address) 1524 Ellamont st

15 Filed 2 7 1929 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25th, 1929, to Sept. 26th, 1929.

that I last saw her alive on Sept. 25th, 1929

and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac E. Dickson, M. D.

Oct. 27 1929 (Address) 3055 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 9/28 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 49601

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49601

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 15-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daisy Holton

(a) RESIDENCE NO. 1672 Lawrence ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed 2 7 1929, 19 ... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1929, to Sept. 26, 1929, that I last saw her alive on Sept. 26, 1929 and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Alcoholism, acute ?

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Pneumonia ?

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

9-27-1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 9/28 1929

20 UNDERTAKER: Wm. Cook — ADDRESS: 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49602

CERTIFICATE OF DEATH

185 E 49602

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 11-24 Ward)

2-FULL NAME Agnes J Henry

(a) RESIDENCE NO. 1322 Linden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 21, 1866

7 AGE: Years 62 | Months 10 | Days 5 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph M Henry

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Pfister

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mrs Sally Henry
(Address) 1322 Linden Ave

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:

Acute Fall
Coma, Status -
Fracture of Femur
(duration) yrs. mos. 6 da.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. 8 da.

18 Where was disease contracted if not at place of death? 1322 Linden

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Wm C Gladden M. D.

19 (Address) 1310 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 9/28 1929

20 UNDERTAKER: Jos Cook — ADDRESS: 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 27 1929

WM. H. HAMPSON JOURNAL CO., PRINTERS

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Rittalata 1038 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49603

CERTIFICATE OF DEATH

43 E 49603

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 Kentucky Ave 8-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph P. Liberto

(a) RESIDENCE NO. 2215 Kentucky Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Josephine Liberto

6 DATE OF BIRTH (month, day, and year) Dec 4th 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John James Liberto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John M. Liberto

(Address) 2215 Kentucky Ave

15 Filed ....., 19.....

2 7 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26/29

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to Sept 26, 1929, that I last saw him alive on Sept 25, 1929 and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cancer Inguine

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Andy L Rittalata M. D.

(Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 28 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul st

Spec.—2-29-28—L. F. S.—500 Bks.

E 49604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 117 E 49604

1—PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. ..... ST. 9-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry German

(a) RESIDENCE NO. Lowson md R.F.D. #6 ST. ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
(a) HUSBAND of
(or) WIFE of Janet German

6 DATE OF BIRTH (month, day, and year) April 11 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Howell German

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant Janet German

(Address) Lowson R.F.D.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

2 7 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1929

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to Sept 27, 1929, that I last saw h[illegible] alive on Sept 27, 1929 and that death occurred, on the date stated above, at 1.30 P.m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix
Peritonitis
Multilocular abdominal abscess

(duration) ... yrs. 5 mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of see over

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S H Bannon, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Sept 30, 29
20 UNDERTAKER	ADDRESS
Frederick Leasburg & Son	Pulaski

Spec.—2-29-28—L. F. S.—500 Bks.

929442 E 49605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+47 E 49605

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

2—FULL NAME Clara Ader

(a) RESIDENCE NO. Golden Ring Rd ST., WARD Baltimore md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 2 ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Leonard Ader

6 DATE OF BIRTH (month, day, and year) Aug 1st 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhemini Mannsa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger—

14 Informant Record—
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 7 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 25— 1929, to Sept- 27 1929, that I last saw h— alive on Sept- 27 1929 and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis from Colostomy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Sigmoid

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Helwig Kosmak, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	9/31 29
20 UNDERTAKER	ADDRESS
Frederick Sasse & Sons	Baltimore

Cor.—10-10-29—A Co.—100 Bks. Also known as Vanus Spencer Myers

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49606

CERTIFICATE OF DEATH

51 ✓ E 49605

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 617 Kirby Lane St., 16-27 Ward)

2-FULL NAME Vasious F. Myers

(a) RESIDENCE NO. 617 Kirby Lane St, Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edgar W.

6 DATE OF BIRTH (month, day, and year) May 13-1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 237
(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Richmond
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Va

14 Informant Edgar W. Myers
(Address) 617 Kirby Lane

15 Filed ....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Acute (duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) 2 yrs. mos. 21 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Hoskins M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

1925 W. SARATOGA NORTH

NRA

Spec.—1-12-23—M&T—500 Blks.

E 49607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 49607

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary 26-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Gay Spurrier

(a) RESIDENCE NO. 3100 Howard Park Avenue ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~of~~ wife of Roland Spurrier

6 DATE OF BIRTH (month, day, and year) Sept 26 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Roanoke, Virginia

PARENTS

10 NAME OF FATHER Robert H Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Husband Spurrier (Address) 3100 Howard Park Ave

15 Filed 2 8 1929 . 19 C. HAMPSON JONES Registrar

By ... Deputy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 26 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-20 . 1929 . to 9-26 . 1929 .

that I last saw her alive on 9-26 . 1929

and that death occurred, on the date stated above, at 11.13 P. m.

The CAUSE OF DEATH* was as follows: -

Mitral Stenosis

Acute cardiac decompensation

(duration) ... yrs. 6 mos 6 days

CONTRIBUTORY (Secondary) Pregnancy - 6 months

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) W. Alexander Norris M. D.

9/26 . 1929 (Address) 24 24 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 30 1929

20 UNDERTAKER Charles L. Ellis — ADDRESS 1202 Pont Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 49608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49608

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1231 Riverside Ave ST., 24th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ferdinand Wagner

(a) RESIDENCE NO. 1231 Riverside Ave ST., 24th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Nalls Wagner

6 DATE OF BIRTH (month, day, and year) Oct 16, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore Transfer Co

9 BIRTHPLACE (city or town) Baltimore
(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Charles Wagner

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Neudecker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Mrs. Ethel Nalls Wagner
(Address) 1231 Riverside Ave

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

SEP 28 1929 By NAM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 20, 1929, to Sept 27, 1929, that I last saw him alive on September 26, 1929 and that death occurred, on the date stated above, at 3.00 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

Sept 27, 1929 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Oct 1, 1929
20 UNDERTAKER Chas. L. Sturm	ADDRESS 1 E Fayette Ave

Spec.—2-29-28—L. F. S.—600 Blks.

E 49609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49609

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1616 E Monument ST. 873 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Taylor Earhardt

(a) RESIDENCE NO. 1616 E Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23-29

7 AGE	Years	Months	Days	If LESS than 1 day, ___hrs. or ___min.
	0	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country)

PARENTS

10 NAME OF FATHER Carroll Earhardt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Minnie Taylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Minnie Taylor Earhardt
(Address) 1616 E Monument St

15 Sept 8 1929, 19 C. CLAMPSON JOHNSON, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 24th, 1929, to Sept 28, 1929

that I last saw h[illegible] alive on Sept 27, 1929

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

General Edema

about 5 or 6 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

Congenital (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Forbes, M. D.

9-29, 1929 (Address) 1612 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Sept 28 1929
20 UNDERTAKER John W Henderson	ADDRESS 1502 E Monument

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49610

CERTIFICATE OF DEATH

90 E 49610

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3130 Ravenwood Ave. 8-40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Lehman

(a) RESIDENCE NO. 3130 Ravenwood Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Meta Lehman

6 DATE OF BIRTH (month, day, and year): Dec 3/1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): Amer. Ice Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Lehman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lisetta Stage

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Fred L. Lehman

(Address) 3130 Ravenwood Ave

15 SEP 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 27/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 19 29 to Sept 27 19 29 that I last saw h alive on Sept 26 19 29 and that death occurred, on the date stated above, at 2 - 20 P.M.

The CAUSE OF DEATH was as follows:

Mitral Regurgitation

4

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1929 (Address) 3130 Ravenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Home	Sept 30 1929
UNDERTAKER: Philip Stern	ADDRESS 2016 Eutaw St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49611

CERTIFICATE OF DEATH

90 E 49611

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 E. Fayette ST. 6-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincenia D'Amelio

(a) RESIDENCE NO. 1529 E. Fayette WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Smithfield N.C.

PARENTS

10 NAME OF FATHER Alfred Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Smithfield N. C.

12 MAIDEN NAME OF MOTHER Lilly Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Father Smith

(Address) 1529 E. Fayette St.

15 SEP 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1929 to Sept 25, 1929 that I last saw h[illegible] alive on Sept 25 1929 and that death occurred, on the date stated above, at 10 1 m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy (duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Walther M. D.

9/27, 1929 (Address) 1525 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Selma N. C.	Sept. 28, 1929
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1725 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

E 49612

HEALTH DEPARTMENT—CITY OF BALTIMORE

169 ✓ E 49612

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Karris' Shore Westport. St., 20-28 Ward)

2-FULL NAME Joseph F. Romm.

(a) RESIDENCE NO. 1927 Christian St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If ~~married, widowed, or~~ HUSBAND of ~~WIFE of~~ Lillian Romm.

6 DATE OF BIRTH (month, day, and year) July 15, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	63	2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Nicholas Romm.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) France.

12 MAIDEN NAME OF MOTHER Hannah --------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Hunter G. Romm. (son)
(Address) 1927 Christian St.

Filed SEP 28 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 25, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Drowning.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Finnandt, M. D.

9/26. 1929 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept. 28 1929
20 UNDERTAKER George L. Schnabel & Son	ADDRESS Westfield, Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49613

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3702 Falls Road ST., 13-52 WARD)

2—FULL NAME Mary E. Slonaker

(a) RESIDENCE NO. 3702 Falls Road ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: John A. Slonaker

6 DATE OF BIRTH (month, day, and year): Oct. 25-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Abram Hesson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John A. Slonaker

(Address): 3702 Falls Road

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

2 8 1929 Per CRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 26-1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 20th, 19 29, to Sept 26th, 19 29, that I last saw h[illegible] alive on Sept 26th, 19 29, and that death occurred, on the date stated above, at 3 35 P. m.

The CAUSE OF DEATH* was as follows:

1 Broncho-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Bad Condition. Senility.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Typical clinical findings

(Signed) H. G. Fiss M. D.

9/26/29. (Address) 3615 Falls Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Marys (Hampden)	Sept 30. 1929
20 UNDERTAKER: Horace M. Dungee	ADDRESS: 3631 Falls Rd.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49614

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49614

REGISTERED NO.

1—PLACE OF DEATH St Joseph Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 27-4 WARD)

2—FULL NAME William Keating

(a) RESIDENCE NO. 304 Evansham ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna McGrath

6 DATE OF BIRTH (month, day, and year) July 6, ~~1858~~ 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6457	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Park Patrolman

(b) General nature of industry, business, or establishment in which employed (or employer) 61

(c) Name of employer Clifton Park

9 BIRTHPLACE (city or town) (State or country) Texas, Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Thomas J. Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hanora Hennegan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Johanna Keating

(Address) 304 Evesham Avenue

15 Filed 2 8 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to 9/28/, 1929, that I last saw h.. alive on 9/25, 1929 and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows:

Focal Infection,
Chronic Myocarditis,
Chronic Nephritis.

(duration) yrs 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation (duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) J. H. Barranco, M. D.

, 19 (Address) St Joseph Hosp —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/1 19 29
20 UNDERTAKER Henry A. Mears & Son	ADDRESS For H. Calvert

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49615

CERTIFICATE OF DEATH

X 44 E 49615

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., [illegible] WARD)

2—FULL NAME Mrs. J. Emory Fleisher

(a) RESIDENCE NO. Union Memorial Hosp. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	11 10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Perry Co. Pa. Newport.

PARENTS

10 NAME OF FATHER George Fleisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Perry Co. Pa.

12 MAIDEN NAME OF MOTHER Mary E. Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Perry Co. Pa.

14 Informant Mrs. J. Emory Fleisher

(Address) Newport Pa.

15 Filed [illegible] 19 HAMPSON JONES M. Registrar

2 8 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 19 29 to Sept. 28, 19 29 that I last saw h~~im~~ alive on Sept. 28, 19 29 and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.
(Post-operative)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? Yes Date of Sept. 26

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Samuel McLandburgh, M. D.

Sept. 19 29 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newport Pa

DATE OF BURIAL 9/28 19 29

20 UNDERTAKER J. M. Cook

ADDRESS 1217 E. Pond St

Spec.—2-29-28—L. F. S.—500 Blks.

E 49616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49616

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 26-36 ST., WARD)

2—FULL NAME Robert Shores n Howard Gibson

(a) RESIDENCE NO. 3010 Spring St., Colgate Creek, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Shores

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lena ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed 2 8 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1929 to Sept. 28, 1929

that I last saw h im alive on Sept. 28, 1929

and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

? Myocarditis, chronic Fatty Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopic Autopsy

(Signed) Marion M. McLean, M. D.

9-28, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashburn Cemetery

DATE OF BURIAL: Sept 28 1929

20 UNDERTAKER: Rendell & Heppd.

ADDRESS: 300 N Eden

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49617

CERTIFICATE OF DEATH

E 49617
REGISTERED NO.

1—PLACE OF DEATH St Joseph Hosp.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1-17 WARD)

2—FULL NAME James Phillips

(a) RESIDENCE NO. Rocks Md ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Married.

6 DATE OF BIRTH (month, day, and year) March 16 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61.	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer; Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Annie J. Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Charles T. Phillips.
(Address) Rocks Md.

15 FILED SEP 29 1929 C. HAMILTON JONES, M. D. Registrar
BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Sept 29, 1929, that I last saw h[illegible] alive on Sept 29, 1929 and that death occurred, on the date stated above, at 1.50 m.

The CAUSE OF DEATH* was as follows:

Acute Retention
Hypertrophied Prostate

(duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Ye Date of 9/19/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S & B Barranco, M. D.

, 19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jarrettsville Cemetery — DATE OF BURIAL Oct 1 1929

20 UNDERTAKER E J Hunt & Sons — ADDRESS Jarrettsville Md

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 49618

1—PLACE OF DEATH

REGISTERED NO. **E 49618**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1508 Clifton Ave ST. 13-59 (WARD)

2—FULL NAME George G. Kelly

(a) RESIDENCE NO. 1508 Clifton Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 10 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 8-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	63	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Street Cleaning Dept

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Blanche Ernest

(Address) 508 Clifton Ave

15 Filed SEP 29 1929 19 H. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27-1929

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1921, to Sept 27, 19 29

that I last saw him alive on Sept 27, 19 29

and that death occurred, on the date stated above, at 11:20 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. R. Miller M. D.

9/30/29 (Address) 2150 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Sept 30 19 29
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	1974 W. North Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49619

CERTIFICATE OF DEATH.

57

E 49619

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 W. Hamburg - ST., 23-31 WARD)

2-FULL NAME Thomas Henry Brown

(a) RESIDENCE NO. 118 W. Hamburg - ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Brown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Laura Brown
(Address) 118 W Hamburg

15 Filed SEP 2 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/26 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/5 .1929. to 9/26 .1929.
that I last saw h[illegible] alive on 9/25 1929.
and that death occurred, on the date stated above, at 10 m.
The CAUSE OF DEATH* was as follows:
Uraemia

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Chr nephritis and Diabetes Mellitus duration yrs. Coronary

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine albumin + sugar

(Signed) Dan Trundle M. D.

9/27 1929 (Address) 1x x W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mag o thy. Cem. DATE OF BURIAL Sept 29, 29

UNDERTAKER John W. Toadvine ADDRESS 1027 Hanover

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49620

CERTIFICATE OF DEATH

90

E 49620

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mark Welsh

(a) RESIDENCE NO. 231 Front ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: Laborer

(b) General natore of Indostry, bosiness, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Mark Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed SEP 30 1929, 19 Per C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 19 29 to Sept. 27, 19 29, that I last saw him alive on Sept. 27, 19 29 and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

myocarditis, chronic and acute

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Town; Secondary in hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General exam; lab.

(Signed) L. C. Lumpkin, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Oct 30. 1929

UNDERTAKER: Henry Lutz

ADDRESS 1203 N. Broadway

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49621

CERTIFICATE OF DEATH

E 49621

1-PLACE OF DEATH

City of Baltimore: (No. 2141 Harford Ave St., 8-45 185 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Molitor

(a) RESIDENCE NO. 2141 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Molitor nee Pahl

6 DATE OF BIRTH (month, day, and year) Dec 7/1849

7 AGE 79. Years	Months	Days	IF LESS than 1 day hrs. or min.
79	9	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Brewmaster
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Bavaria Germany

PARENTS

10 NAME OF FATHER Martin Molitor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude ---------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Molitor
(Address) 2141 Harford Ave

Filed 19 HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 20/29 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia(Terminal)
(Accidently fell down stairs at his residence Sep 13/29)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Concussion of brain,
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/27/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudens Park	Sept 30 1929
20 UNDERTAKER Chas. L. Skinner	ADDRESS 1537 Eutaw

P 2 9 1929

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49622

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49622

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. 16-22 WARD) or

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Naddie Garonzik (Nettie)

(a) RESIDENCE NO. 1521 Riggs Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Garonzik.

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-keeper.

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mannie Rubid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rothbrown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. F. Rosen

(Address) 2377 N. Bilma Av.

15 FILED SEP 29 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1929, to Sept. 27, 1929, that I last saw her alive on Sept. 27, 1929, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 9/24/29

Was there an autopsy? Yes.

What test confirmed diagnosis? Resp. Caused.

9/27, 1929 (Signed) A. R. Wilkerson M. D. (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Rem	9/29 19 29
20 UNDERTAKER Jack Levin	ADDRESS 1439 E Balt St

Spec.—1-12-23—M&T—500 Bks.

E 49623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 49623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2816 Goodwood Road, Hamilton ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solon L. Wonders

(a) RESIDENCE No. 2816 Goodwood Rd. Hamilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Minnie K. Wonders

6 DATE OF BIRTH (month, day, and year) April 11, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 2 years

(c) Name of employer

9 BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14
Informant Beatrice Beck
(Address) 2816 Goodwood Rd. Hamilton

15
Filed SEP 29 1929 C. HAMILTON JONES, M. D.
Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1929.

17
I HEREBY CERTIFY, That I attended deceased from 9/24, 1929, to 9/27, 1929.
that I last saw h— alive on 9/27, 1929
and that death occurred, on the date stated above, at 3:35 A. m.
The CAUSE OF DEATH* was as follows:

Carcinoma
Liver - Gall - Bladder
Etc

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Nyle W. Fordney M. D.
, 19 (Address) 5103 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Sept. 30, 1929

20 UNDERTAKER Fred Loseke Sons — ADDRESS Fullerton

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49624

CERTIFICATE OF DEATH

91-002 V

E 49624

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4206 Willoughby Ave ST., 46-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Schmidt

(a) RESIDENCE NO. 4206 Willoughby ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schmidt

6 DATE OF BIRTH (month, day, and year) March 4 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	6	23 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Gunster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. D. Klein

(Address) 420 Willoughby Ave

15 Filed SEP 29 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27" 29

17

I HEREBY CERTIFY, That I attended deceased from May 5", 1929, to September 27, 1929, that I last saw h alive on September 26, 1929 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis

(duration) yrs. 4 mos. 21 ds.

CONTRIBUTORY (Secondary) Gangrene Left Heel From Diabetes

(duration) yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb R. Bittinger, M. D.

Sept 27, 1929 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	9/30 1929
20 UNDERTAKER L. J. Rueck	ADDRESS 6405 Sefton Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49625

CERTIFICATE OF DEATH

129 E 49625

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Dunn

(a) RESIDENCE NO. 302 S. Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Dunn

6 DATE OF BIRTH (month, day, and year) ~~Unknown~~ 1898 Feb 28

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework and

(b) General nature of Industry, business, or establishment in which employed (or employer) Packing house

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed SEP 29 1929 C. HILLERY JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1929 to Sept. 27, 1929

that I last saw her alive on Sept. 27, 1929

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Married (duration) 5 yrs. : mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) L. A. Lumpkin, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patrick's Cem	Sept 30 1929
20 UNDERTAKER	ADDRESS
Martin W. E. Dieterlen	37th Ave &

Cor.—10-10-29—A Co.—100 Bks.

E 49626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49626

31 [redacted]

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 604 S. Green St. 9-7-30 Ward)

2-FULL NAME George Wilson

(a) RESIDENCE NO. 604 S. Green St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mattie Wilson

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Henritta Johnson

13 BIRTHPLACE OF MOTHER (City or town)
(State or country) Va

14 Informant Mr. William Wilson
(Address) 3319 Weedon Ave

Registrar

EP 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemoptysis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.

9/28. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Sept 29 1929
20 UNDERTAKER Samuel D. Hemsley	ADDRESS 578 W. Biddle

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49627

E 49627

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49627.

CERTIFICATE OF DEATH

REGISTERED NO. E [illegible]

1—PLACE OF DEATH Union Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33rd & Calvert St ST., 12 WARD)

2—FULL NAME Mrs David White (Elizabeth)

(a) RESIDENCE NO. Braddock Heights, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David White

6 DATE OF BIRTH (month, day, and year) Dec 3, 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John M. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Findlay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant John F White

(Address) Braddock Heights Md

15 Filed 2 9 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29/29

17 I HEREBY CERTIFY, That I attended deceased from 9/24/29, 19..., to 9/29/29, 19..., that I last saw h[illegible] alive on 9/29/29, 19... and that death occurred, on the date stated above, at 6.36 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Postoperative collapse

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 9/27/29

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) James Cullen Weinberg, M. D.

9/30/1929 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Boonsboro Mausoleum	Oct 2 1929

20 UNDERTAKER William H Bast & Son ADDRESS Boonsboro Md

Spec.—2-29-28—L. F. S.—500 Blks.

F

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49628

CERTIFICATE OF DEATH

E 49628

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Fisher

(a) RESIDENCE NO. 189 North Shore, Penns Grove, N.J WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) Balto. City Hospitals

15 Filed SEP 29 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1929 to Sept. 27, 1929

that I last saw her alive on Sept. 27, 1929

and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam & Lab.

(Signed) E. U. Lumpkin M. D.

9-28, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Penns Grove N.J.	9-30 1929
20 UNDERTAKER	ADDRESS
Samuel Easton	916 Race

Spec.—2-29-28—L. F. S.—500 Bks.

229438 E 49629.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 49629. × 91-001 E 49629

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James M. Morton

(a) RESIDENCE NO. Marysville Tenn ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Inez

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Gardener

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER Andy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Vera Griffen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed SEP 29 G. HARRISON JONES, M. Registrar

by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1929, to Sept 29, 1929, that I last saw h. living alive on Sept 29, 1929 and that death occurred, on the date stated above, at 2 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteres-Venous aneurysm

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 9/28/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Clarence E. Gardner Jr. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Knox Dem

DATE OF BURIAL 9/29 1929

UNDERTAKER John Welch

ADDRESS 502 Cathedral

Spec.—2-29-28—L. F. S.—500 Blks.

E 49630 HEALTH DEPARTMENT—CITY OF BALTIMORE

V 91-002 49630

E 49630

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2210 Booth St. ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Kraushofer

(a) RESIDENCE NO. 2210 Booth St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Kraushofer

6 DATE OF BIRTH (month, day, and year) March 12, 1856

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 0"7

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Prabst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14

Informant Emil Kraushofer

(Address) 2210 Booth St.

15

2 9 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929, to Sept 26, 1929, that I last saw h.. alive on Sept 25, 1929 and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH* was as follows:

arterio Sclerosis

(duration) yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Gustav Ries M. D.

Sept 28 1929 (Address) 1502 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Sept. 30 1929

20 UNDERTAKER Henry H. Wetzel ADDRESS 1534 W Lombard St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49631

CERTIFICATE OF DEATH. x 129 ✓ E 49631

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 111 Glen Hospital (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisha E Thomas

(a) RESIDENCE NO. Delta Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Wid.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/11/1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Delmar Thomas

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah England

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Record

15 Date received 9 30 1929, 19 [illegible] Registrar

E. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.29.29

17 I HEREBY CERTIFY, That I attended deceased from 9.27.29 to 9.29.29, that I last saw h[illegible] alive on 9.29.29, 19 11 45 p m., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH was as follows: Chronic Myocarditis Arterio Renal Disease

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical.

What test confirmed diagnosis?

Signed [illegible] M. D.

Address [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta, Pa.

DATE OF BURIAL 9/30 1929

20 UNDERTAKER W. J. Tickner & Sons

ADDRESS No. Pa.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 49632

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 14-20 WARD)

2-FULL NAME Bertha J. Smith

(a) RESIDENCE NO. 1805 Druid Hill Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December .

7 AGE — Years: 46 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self

(Address)

Dec 30 1929 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Sept 29, 1929, that I last saw h e alive on Sept 29, 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Anemia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood & urine

(Signed) Geo. McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel

DATE OF BURIAL: 10/2/1929

20 UNDERTAKER: Mrs. Chas. H. Holland

ADDRESS: 1921 Druid Hill

Spec.—1-12-23—M&T—500 Bks.

Irby.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49633

CERTIFICATE OF DEATH.

16-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 2200 WARD)

REGISTERED E 49633

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millie Irby

(a) RESIDENCE NO. 620 Conway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE — Years: 36 — Months: — — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self

(Address)

Filed SEP 30 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Sept 27, 1929, that I last saw h[illegible] alive on Sept 27, 1929, and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Liver Abscess

(duration)? yrs. mos ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) George McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 10/1/1929

UNDERTAKER: Mrs. Les. H. Holland — ADDRESS 1631 Druid Hill

Spec.—1-12-23—MAT—500 Blks.

E 49634 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49634
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 W Lanvale ST. 17-24 WARD)

2-FULL NAME Susie Bunney

(a) RESIDENCE NO. 715 Lanvale ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob

6 DATE OF BIRTH (month, day, and year) ? 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Patsie Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant Lena Bunney
(Address) 703 Lanvale St.

Filed SEP 30 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1929, to Sept 26, 1929, that I last saw h[illegible] alive on Sept 26, 1929, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Fatty degeneration

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] Woolery M. D.

1-25 1929 (Address) 703 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 9/30/1929

20 UNDERTAKER Mrs. Geo. A. Holland — ADDRESS 163 N. Dund Fulton

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49635

CERTIFICATE OF DEATH

179

E 49635 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 21-29 Ward)

2-FULL NAME Mary C Boyd

(a) RESIDENCE NO. 713 N Hamburg St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
[redacted]	White	[redacted]

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred. I Boyd.

6 DATE OF BIRTH (month, day, and year) June 7 1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	73	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Reilhoetz

11 BIRTHPLACE OF FATHER (City or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (City or town) Not Known
(State or country)

14 Informant Mrs Grace Alt
(Address) 713 N Hamburg

[illegible] 1929

[illegible] HAMPSON JONES, M.D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:

ADC Burns
1-2-3 degree
Face Hands & Legs (Extent)

CONTRIBUTORY (duration) — yrs. — mos. 1 ds.
(Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 713 N. Hamburg

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Examination

(Signed) H C Reads, M. D.

. 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	9-30 1929
20 UNDERTAKER Bernard C Harker	ADDRESS 1008 Park

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49636

CERTIFICATE OF DEATH

90 ✓

E 49636
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 4725 Keswick St., 27-53 Ward

2-FULL NAME Louise Gott Miner

(a) RESIDENCE NO. 4725 Keswick St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R Miner

6 DATE OF BIRTH (month, day, and year) Dec 18th 1860

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
68	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At Home

9 BIRTHPLACE (city or town)
(State or country) Ann Arbor Mich.

PARENTS

10 NAME OF FATHER Jacob Buttorfield Gott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Caroline M Burger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.Y.

14 Informant John R Minor
(Address) 2439 N. Charles st

Filed 1929 C. HAMSBURY JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

6 (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) H C Slades M. D.

(Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ann Arbor Michigan	4/30 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Emmett 1406 Hanover Bldg 6-7

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49637

1—PLACE OF DEATH

CERTIFICATE OF DEATH

74001

E 49637

REGISTERED NO.

CITY OF BALTIMORE: (No. 3013 Mathews ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sigmund Himmelmann

(a) RESIDENCE NO. 3013 Mathews ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Estella Himmelmann

6 DATE OF BIRTH (month, day, and year): June 10, 1877

7 AGE — Years: 52 | Months: 3 | Days: 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer 061

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: City of Balto

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Friedrich Himmelmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christine Hirth

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss E. Himmelmann

(Address) 3013 Mathews

15 Filed: EP 30 1929

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 27. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 19 29 to Sept 27 19 29

that I last saw h alive on Sept 27 19 29

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Owen Dorsey M. D.

9/29 19 29 (Address) 4706 Hanover Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: 9/30 1929

20 UNDERTAKER: H. M. Cook

ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

Gaver

E 49638 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 V

E 49638

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Gaver

(a) RESIDENCE NO. 2110 Homewood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles B Gaver

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Josiah Butt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Cramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rose L Gover

(Address) 824 E 22nd St

15 Filed 1 30 1929, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29/29

17 I HEREBY CERTIFY, That I attended deceased from 9/28/29, 19..., to 9/29/29, 19..., that I last saw h.. alive on 9/29/29, 19..., and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of colon

(duration) Two Months yrs. mos. ds.

CONTRIBUTORY (Secondary) toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9/28/29.

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) M. Hurdis M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 10/1 1929

20 UNDERTAKER H. Cook

ADDRESS 1214 E Baltimore St

S[illegible]—2-29-28—L. F. S.—500 Blks.

49639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-002

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Saubend + Green ST. 21-29 WARD)

REGISTERED NO. E 49639

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothy Phillips

(a) RESIDENCE NO. 916 Ryan ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): Mar 23. 1929

7 AGE: Years — Months: 6 — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: John S Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Catherine Phillips

(Address): 916 Ryan St

15 Filed [illegible] 19 [illegible] [illegible] JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1929, to Sept 26, 1929, that I last saw her alive on Sept 26, 1929, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus, 1

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) W. B. Johnson, M. D.

Sept 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: 9/30 1929

20 UNDERTAKER: H. Cook

ADDRESS: 1217 E Pratt St

Spec.—1-12-23—M&T—500 Bks.

E 49640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 49640

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 McKewin Ave ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude L. Finnan

(a) RESIDENCE NO. 723 McKewin Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ (or) WIFE of Elmer J. Finnan 1896

6 DATE OF BIRTH (month, day, and year) July 4 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Black Creek N.C.

PARENTS

10 NAME OF FATHER Robert Brissette

11 BIRTHPLACE OF FATHER (city or town) (State or country) Black Creek N. C.

12 MAIDEN NAME OF MOTHER Anna Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Black Creek N.C.

14 Informant Mrs. Ruth Cummings

(Address) 723 McKewin Ave.

SEP 30 1929

..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1929

17

I HEREBY CERTIFY, That I attended deceased from Apr. 27, 1929, to Sept 29, 1929

that I last saw h[illegible] alive on Sept 29, 1929

and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

CONTRIBUTORY (Secondary) (duration) Chr. Myocarditis yrs. 3 mos. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown M. D.

(Address) 1663 N North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilson, N. C. DATE OF BURIAL 9/30/29

20 UNDERTAKER George D. Ruth ADDRESS 1735 Hanford

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49641 V 1886 103 E 49641

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Balto Hosp St. 24-33 Ward)

2-FULL NAME Mary L. Marshall

(a) RESIDENCE NO. 1211 Wall St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	none

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 20 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Lewis Meredith Marshall

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Cecelia C Morgan

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Marshall
(Address) 1211 Wall st

15 Filed Sept 30, 1929 Registrar

30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull
Struck by auto while crossing in front of 1201 Marshall St.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Concussion
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 1201 Marshall

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

9/29 19 29 (Signed) H. Frame M. D.
(Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dworetz Cemetery	Sept 30 1929
20 UNDERTAKER Margaret L. Flynn	ADDRESS 1422 Light St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

229240
E 49642
1—PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

155 E 49642
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

2—FULL NAME William Kolomaznik

(a) RESIDENCE NO. 830 W. Chester St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. 5 mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28 1929.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER William
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Sophie Dasen
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14
Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15
FILED SEP 30 1929, 19 W. Registrar
C. HAMILTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-28-1929

17
I HEREBY CERTIFY, That I attended deceased from Sept--19--, 1929, to Sept 28, 1929.
that I last saw h.. alive on Sept 28, 1929
and that death occurred, on the date stated above, at 1.55 A m.

The CAUSE OF DEATH* was as follows:
Staphylococcus meningitis

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Osteomyelitis of jaw
(duration) yrs. 2½ mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Staph in spinal fluid
(Signed) J W Bickford Jr, M. D.
9-29-1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Sept 30 1929
20 UNDERTAKER	ADDRESS
August Pasch.	2406 Ashland ave.

Spec.—2-29-28—L. F. S.—500 Bks.

SPILMAN

E 49643

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 49643

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 Poplar Grove St. 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Frederick Spilman

(a) RESIDENCE NO. 1036 Poplar Grove ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie A. Spilman

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1858

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	70	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work sheet metal worker

(b) General nature of industry, business, or establishment in which employed (or employer) (retired)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto., Md —

PARENTS

10 NAME OF FATHER John Spilman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Gantenbein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Katie A. Spilman

(Address) 1036 Poplar Grove St.

15 Died [illegible] 19 C. H. THOMPSON JONES, M. D.

P 30 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1929, to Sept 27 1929.

that I last saw him alive on Sept 27, 1929

and that death occurred, on the date stated above, at 10:40 a. m.

The CAUSE OF DEATH* was as follows:

generalized arteriosclerosis

(Senility)

(duration) about 3 or 4 yrs — yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac failure

(duration) yrs 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical tests

(Signed) George A. Knipp, M. D.

, 19 (Address) 3035 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park	9/30/1929
20 UNDERTAKER Geo. Weber & Son 2503	ADDRESS Edmondson Ave

Spec.—1-10-21—M&T—1500 Bks.

Bagley,

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49644

CERTIFICATE OF DEATH.

128

E 49644

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Division St. 17-24 WARD)

2-FULL NAME Herman Bagley

(a) RESIDENCE No. 1317 Division WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundry Driver

(b) General nature of industry, business, or establishment in which employed (or employer): Laundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Duncan Bagley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant: Frank Mitchell, (Address) 1317 Division St.

15 Filed ... 19 ... Registrar

C. HAMPTON JONES, M. D.

P 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/27 19 29.

17 I HEREBY CERTIFY, That I attended deceased from 9/27, 1929, to 9/27, 1929, that I last saw him alive on 9/27, 1929, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Lobar pneumonia

(duration) 4 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Duration for Life

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Cline M. D.

19 (Address) 92 Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL 9-30 1929

20 UNDERTAKER: George T. W. Gilson — ADDRESS 1735 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49645 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 49645

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 S Dallas St WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George F Hoffman

(a) RESIDENCE NO. 628 S Dallas St WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

10 NAME OF FATHER Adam J Hoffman

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Marie Landon

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Adam J Hoffman
(Address) 628 S Dallas St

FILED SEP 30 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1929

17 I HEREBY CERTIFY, That I attended deceased from September 27 19 29 to Sept 28 19 29 that I last saw h~~im~~ alive on Sept 28 19 29 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

(Address) 14 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Sept 30 29

20 UNDERTAKER M. E. Wagner ADDRESS 37 Lombard

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49646 — CERTIFICATE OF DEATH — X 33 — E 49646

1—PLACE OF DEATH — REGISTERED NO. _____

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Byrd Harmon

(a) RESIDENCE NO. Odenton ST. Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of J. J Harmon

6 DATE OF BIRTH (month, day, and year) Oct 27 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant B B Williams

(Address) Waltsburg Md

15 Filed Oct 30 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1929

17

I HEREBY CERTIFY, That I attended deceased from August 26, 1929, to Sept. 29, 1929, that I last saw her alive on September 29, 1929 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Tumor of large bowell
probably Tuberculous

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Obstruction

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/29/29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Samuel T. Hebb, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Highland Howard Co — DATE OF BURIAL Oct 1 1929

20 UNDERTAKER B. T. Williams Son — ADDRESS Waltsburg Md.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49642

CERTIFICATE OF DEATH

38 E 49647

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Shure

(a) RESIDENCE NO. 1101 S. Ellwood Ave. ST., / WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roy Shure

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Work

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Swick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed SEP 30 1929, HAMILTON JONES, M. D. Registrar

P 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 29, 1929, to Sept. 27, 1929, that I last saw her alive on Sept. 27, 1929 and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

" 5 C 798

over 2 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) Marvin M. McLaw, M. D.

9-28, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept. 30 1929
20 UNDERTAKER Lilly & Feiler Inc	ADDRESS 4005 Wash Blvd

Cor.—10-10-29—A Co.—100 Bks.

E 49648

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 49648

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Fairmount & 5th St., 1-1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry D Betzold

(a) RESIDENCE NO. 2817 Hudson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addies Betzold

6 DATE OF BIRTH (month, day, and year) June 30. 1862

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
67	2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer at Plant.
(b) General nature of industry, business, or establishment in which employed (or employer) of Hunde & Daniels
(c) Name of employer Balto. Md.

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER William Betzold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Gertrude Rebmeyer.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Addie Betzold
(Address) 2817 Hudson St.

15 Filed SEP 30 1929 19.. G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Farmer's Light

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 2 1929
20 UNDERTAKER Lloyd Zeiler Son.	ADDRESS 4038 Wash

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

Loraine Harrison

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 49649

CERTIFICATE OF DEATH x 31

E 49649

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Loraine Harrison

(a) RESIDENCE NO. Nt. Pt Road & Wise Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 7 days How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10/28

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	3	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Horace Harrison

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md,

12 MAIDEN NAME OF MOTHER Bertha Sowers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Horace Harrison
(Address) Nt. Pt. Road & Wise Ave

Filed SEP 30 1929 HAMPSON JONES, M. D. Registrar

Dat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 28/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bilateral Pulm Tuberculosis

Tubercular meningitis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature], M. D.

9/30 19 29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	sept 30 19 29
20 UNDERTAKER Edward Bryan	ADDRESS 1691 orleans st

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49650

CERTIFICATE OF DEATH

111-001 ✓

REGISTERED 49650

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. JOHNS HOPKINS HOSPITAL St., 1-3 Ward)

2-FULL NAME THOMAS A. WHITE

(a) RESIDENCE NO. 601 S. Glover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth White

6 DATE OF BIRTH (month, day, and year) September 20, 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54	0	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer Canton Box Co.

9 BIRTHPLACE (city or town) New York State
(State or country)

PARENTS

10 NAME OF FATHER Adolph White

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mrs. Elizabeth White (Wife)
(Address) 601 S. Glover St.

19 ..... Registrar

SEP 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonotis- Perforated Gastric Ulcer

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? Ye Date of Sep 27/29

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis? .....

(Signed) John Cain, M. D.

9/30/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Oct. 1. 1929
20 UNDERTAKER Henry Sander & Sons Inc	ADDRESS BALTIMORE ST & BROADWAY.

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49652

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 155 ✓ E 49651

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST. 4-7 ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Everd

(a) RESIDENCE NO. Pasadena Md. ST. ..... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. less than ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Steven Everd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Heiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr Steven Everd

(Address) Green Haven Annapolis

15 FILED SEP 30 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28, 1929

17

I HEREBY CERTIFY, That I attended deceased from 9-27, 1929, to 9-28, 1929, that I last saw him alive on 9-28, 1929 and that death occurred, on the date stated above, at 2 45 A m.

The CAUSE OF DEATH* was as follows:

Subperiosteal abscess right femur

..... (duration) ..... yrs. ..... mos. 6+ ds.

CONTRIBUTORY (Secondary) Septicemia

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 9/29/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) J Leyko, M. D.

9/28, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co	Oct 1 1929
20 UNDERTAKER John F Denny	ADDRESS 715 Lig St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49652

CERTIFICATE OF DEATH

90 E 49652

1-PLACE OF DEATH

City of Baltimore: (No. 3209 Brighton St. 16-67 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida R. Brickhead

(a) RESIDENCE NO. 3209 Brighton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos F Brickhead.

6 DATE OF BIRTH (month, day, and year) Dec 2 1853

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	9	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Sam Owings

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Brown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs Jos F. Brickhead
(Address) 3209 Brighton St

15 [illegible] C. HAMPSON JONES, M. D.
Registrar

SEP 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 28th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart (duration) Sudden hrs. or ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Sept 30 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ✓ E 49653

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morris Jamison

(a) RESIDENCE NO. 1223 Bayard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

6 DATE OF BIRTH (month, day, and year) teeth

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bernard Jamison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Alberta Jamison

(Address) 501 Belmont St.

15 Filed SEP 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1929 to Sept 27, 1929

that I last saw him alive on Sept 26, 1929

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic cardiovascular disease Chronic valvular heart disease Congestive heart failure auricular fibrillation, syphilis (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Heart block - (duration) yrs. few hours mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) W. F. Varney, M. D.

, 19 (Address) Univ. of Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	9/30 1929
20 UNDERTAKER Walter B. Speiser	ADDRESS 1514 Hanover St.

Cor.—10-10-29—A Co.—100 Bks.

George Demmerlein

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49654

44 E 49654

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 133 N. Duncan St., 6-10 Ward)

2-FULL NAME George Demmerlein

(a) RESIDENCE NO. 133 N. Duncan St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 22/1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, bosiness, or establishment in which emplnyed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Nicholas Derferlein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Kundigna Derferlien

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Smith
(Address) 420 N. Highland Ave

15 Filed 9 30 1929, 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Tuberculosis of throat
or Malignancy of throat

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos Walter, M. D.

9/30/29 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 1 1929
20 UNDERTAKER M. E. Dippel Sr.	ADDRESS 314 Cam

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

49655 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 49655

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3908 Walnut Ave. ST. Overlea WARD)

2-FULL NAME Columbus Barke

(a) RESIDENCE No. 3908 Walnut Ave. ST. Overlea WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha E. Barke

6 DATE OF BIRTH (month, day, and year) Nov. 9th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) Monumental Theodore Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Columbus Barke

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Habich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Bertha V. Barke (Address) 3908 Walnut Ave. Overlea

15 Filed Sept. 30 19 29 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10 19 29 to Sept 29 19 29

that I last saw him alive on Sept 29 19 29

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Cardiac Hypertrophy

Chr. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) H. B. Slaughter M.D.

(Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Oct 2 19 29

20 UNDERTAKER Frederick Lasselhorn Sons ADDRESS Fullerton

HAMPSTEAD, MD.

Spec.—1-12-23—M&T—500 Bks.

E 49656 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 49656

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 E. North Ave ST. 4-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Balzer

(a) RESIDENCE NO. 902 E. North Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) June 24, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk in Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer): Confectionery store

(c) Name of employer: Chas P. Balzer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John C. Balzer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary L. Geis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Chas P. Balzer, Brother

(Address) 902 E. North Ave

15 Filed JUN 7 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19 29, to Sept 29, 19 29, that I last saw h[illegible] alive on Sept 29, 19 29, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 14 29

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) F. J. Kirby M. D.

20. 19 29 (Address) 910 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer Cem	Oct 2 1929

20 UNDERTAKER: Edward W. Conklin ADDRESS 9748 E. Eager Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49652

CERTIFICATE OF DEATH

129 L

E 49652

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 433 S. Parrish ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Flora A. Schmidt

(a) RESIDENCE NO. 433 S. Parrish ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dietrich Schmidt

6 DATE OF BIRTH (month, day, and year) June 4, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Nulta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Catherine Schmidt

(Address) 433 S. Parrish St.

15 Filed 9/30 1929 C. HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1929, to Sept 28, 1929, that I last saw her alive on Sept 27, 1929, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical + Lab findings

(Signed) James W. Ginsberg M. D.

9/30 1929 (Address) 1729 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 1, 1929
20 UNDERTAKER Dept 18 Cook	ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

Hammond

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49658 ✓ 90 E 49658

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Sarah Ann ST., 18-26 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta Barnes Hammond

(a) RESIDENCE NO. 1114 Sarah Ann ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced (or) WIFE of: William Hammond

6 DATE OF BIRTH (month, day, and year): Aug 2, 1879

7 AGE: Years 50 | Months 1 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md

10 NAME OF FATHER: Richard Pendal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hagerstown Md.

12 MAIDEN NAME OF MOTHER: Matilda Penney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hagerstown Md.

14 Informant: Wm. Hammond

(Address): 1114 Sarah Ann St

15 Filed SEP 30 1929, 19 H. LAMPTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-29-29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1929, to Sept 29, 1929, that I last saw her alive on Sept 27, 1929, and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Insuff.

(duration) yrs. 1 mos. 9 ds.

CONTRIBUTORY (Secondary): Anemia Febricula

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab.

(Signed) N. Mateo Williams M. D.

9-30, 1929 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL: Oct 1 1929

20 UNDERTAKER: Mrs Hallie P. Williams — ADDRESS: 322 N. Schroeder

Spec.—1-12-23—M&T—500 Bks.

E 49659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 49659

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 Hughes ST. 22-30 WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Alice Tazwell

(a) RESIDENCE No. 106 Hughes ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~: Andrew Tazwell

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): North Thumberland Co. Va.

PARENTS

10 NAME OF FATHER: Henry Chinn

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Thumberland Co Va

12 MAIDEN NAME OF MOTHER: Laura Crindell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Thumberland Va

14 Informant: Andrew Tazwell

(Address) 106 N Hughes St

15 Received SEP 30 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-1929

17

I HEREBY CERTIFY, That I attended deceased from 9-17-29, 1929, to 9-27, 1929, that I last saw h[illegible] alive on 9-27, 1929, and that death occurred, on the date stated above, at 1230 P m.

The CAUSE OF DEATH* was as follows:

Acidosis; Diabetic Coma

Myocarditis + nephritis

Arteriosclerosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

nephritis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical History

(Signed) Wm C. Bowles M. D.

, 19 (Address) 709 Hamburg St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery

DATE OF BURIAL: Sept 30 19 29

20 UNDERTAKER: Wm Kates R Thomas

ADDRESS 3 E N Schroeder

Cor.—10-10-29—A Co.—100 Bks.

Hilte

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49660

E 49660

CERTIFICATE OF DEATH

161-006

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1810 N. Dallas St., (8-17 Ward)

2-FULL NAME Paul Hilte

(a) RESIDENCE NO. 1810 N. Dallas St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 27/29

7 AGE	Years	Months	Days	IF LESS than 1 day 23 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Leroy Hilte

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Margaret Reckling

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Leroy Hilte
(Address) 1810 N. Dallas St

15 Filed SEP 30 1929 CAROLINE JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 28-29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature -
7 months gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Haller M. D.

9/30/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	9/30/29
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Aisquith

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

49661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49661

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Bank St. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agness Skweres

(a) RESIDENCE NO. 1504 Bank St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Kmieciak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknowin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant M. Skweres

(Address) 1504 Bank St

15 Filed 3 8 1929, 19 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28/29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1929, to Sept. 28, 1929,

that I last saw h alive on Sept. 28, 1929

and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation 3 days
Diarrhoea 2 weeks
Oty protatic Pneumonia 2 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Diarrhoea at Aberdeen

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) A. F. Klis, M. D.

Sept 30, 1929 (Address) 24 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cer. Hl. Rd.	10/1 1929
20 UNDERTAKER	ADDRESS
J W Ozazewski 1930	Eastern a

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49662

CERTIFICATE OF DEATH

129

E 49662

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1203 Carroll St. ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A. McKeldin

(a) RESIDENCE NO. 1203 Carroll St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy A. McKeldin

6 DATE OF BIRTH (month, day, and year) Sept. 22 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James McKeldin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dora Grief

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. McKeldin

(Address) 1203 Carroll St

15 Filed SEP 30 1929 19 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28/29.

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to September 28, 1929.

that I last saw h alive on September 28, 1929.

and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Behnisch M. D.

, 19 (Address) 1357 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 10/2 1929

20 UNDERTAKER I. Frew McCully

ADDRESS 130 E. Fort.

Spec.—2-29-28—L. F. S.—800 Blks.

E 49663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 49663

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 9-9 WARD)

If death occurred in a hospital or institution give its NAME instead of street and number.)

2—FULL NAME Maria McClaine

(a) RESIDENCE NO. 1610 McElderry St. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Missionary

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Thomas Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nellie Bird

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant: Records of

(Address) Baltimore City Hospitals

15 FILED SEP 30 1929 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1929, to Sept. 28, 1929

that I last saw her alive on Sept. 28, 1929

and that death occurred, on the date stated above, at 1:40 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Endocarditis

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic cardiac dilatation

(duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? Home; Secondary to Myo.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General exam.

(Signed) L. M. Lumpkin, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct. 1 1929

20 UNDERTAKER Chris. H. Johnson ADDRESS 416 N. Gilmor St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49664

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2049 Woodbury Ave ST., 13-57 WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elisha E Connelly

(a) RESIDENCE NO. 2049 Woodbury Ave ST. 13-57 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Connelly

6 DATE OF BIRTH (month, day, and year) April 17 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edward Connelly

(Address) 2049 Woodbury Ave

15 Filed ..... 19 ..... HAMPSON JONES JR. Registrar

JUL 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1929

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 29, 1929, that I last saw him alive on July 29, 1929, and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH* was as follows:

Cardiovascular Renal disease

Indefinite

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) H H Pedersen M. D.

(Address) 855 N 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Oct 1 19 29

20 UNDERTAKER Chenowith Son

ADDRESS 361 Cathedral

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49665

CERTIFICATE OF DEATH

118-002

E 49665

1—PLACE OF DEATH University Hospital REGISTERED NO. 70-67

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth O'Brien

(a) RESIDENCE NO. 2685 Dulaney St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Dannuck O'Brien

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE | Years 34 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Dannuck O'Brien

(Address) 2685 Dulaney St

15 Date 9 30 1929, 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29-29

17 I HEREBY CERTIFY, That I attended deceased from 9-19, 19 29, to 9-29, 19 29

that I last saw h[illegible] alive on Sept. 29, 19 29

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-20-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. W. Lake, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral | DATE OF BURIAL 9-2 1929

20 UNDERTAKER H. B. Cunningham 1136 | ADDRESS Poplar Grove st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49666

CERTIFICATE OF DEATH

E 49666

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 22-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Wheeler

(a) RESIDENCE NO. 703 S Green St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 - 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hopwood Express Co.

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Randolph Wheeler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lottie Matthews

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Charles Wheeler (Uncle)
(Address) Elkridge, Md.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar.
Dep

3 0 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contusion of small intestine due to being struck in abdomen with barrel (Accidental Death)

yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 306 S. Paca St

Did an operation precede death? Yes Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

9/30, 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge Md.	Oct 1929
20 UNDERTAKER	ADDRESS
James E. Wright	964 Mary

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 49667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 49667

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 N. Wolfe St. 6-9 WARD)

2-FULL NAME Benj T Willard

(a) RESIDENCE NO. 134 N. Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olive Willard

6 DATE OF BIRTH (month, day, and year) Aug 31-1883

7 AGE	Years	Months	Days	If LESS than 1 day..... hrs. or.... min.
	46	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) O & S

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Clayton F Willard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Olive Willard

(Address) 134 N. Wolf St

15 Filed 1 1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 27 1929 to Sept 29 1929.

that I last saw him alive on Sept 28 1929

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) John W Wade M. D.

Sept 29 1929 (Address) 1118 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL Oct 1st 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 49668 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **E 49668**

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1100 Whitelock St. St. 13-54 Ward)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Edward Irvin Stanley

(a) RESIDENCE NO. 1100 Whitelock St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Clara Stanley

6 DATE OF BIRTH (month, day, and year): July 9th 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of Industry, business, or establishment in which employed (or employer): B & O.

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Josiah Stanley

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Caroline

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant (Address): Clara Stanley 1100 Whitelock St

15 FILED 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

September 28, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to Sept. 28, 1929, that I last saw him alive on Sept. 28, 1929, and that death occurred, on the date stated above, at 4:12 A.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage and Uremic Coma (C.H.) (Coma)

(duration) yrs. 3 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. White, M. D.

, 19 (Address) 1021 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem Date of Burial: Oct 1st 1929

20 UNDERTAKER: Jas Rv. Skinner 1620 E. Mad St ADDRESS

Very Important. See Instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Meyer, 1031 N Caroline St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49669

CERTIFICATE OF DEATH

90

E 49669

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2307 E Federal ST. 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma L. Dukehart

(a) RESIDENCE NO. 2307 E Federal ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 30, 1869

7 AGE: Years 59 | Months 10 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: National Biscuit Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas M Dukehart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Victoria Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cuba Md

14 Informant: Mabel Sanford

(Address) 2307 E Federal St

15 Filed 1 1929, 19 H. JACKSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 28 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10 1929 to Sept. 28 1929

that I last saw h... alive on Sept. 27 1929

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Fulminant Heart disease

General Edema 1 yrs. mos. ds.

(duration)

CONTRIBUTORY (Secondary) (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Walter A. Meyer, M. D.

9/30, 1929 (Address) 1032 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: Oct 1st 1929

20 UNDERTAKER: W. H. Cook

ADDRESS: 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49670

CERTIFICATE OF DEATH

90 ✓

E 49670

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 15-22 Ward)

2-FULL NAME Mary Hacker

(a) RESIDENCE NO. 1347 Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ... min.
	63	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Elias Peggy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Franklin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant William Seagure
(Address) 1377 N. Fulton Ave

Filed 10-1-1929 H. WILSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Edw Gladis M. D.

. 19 (Address) 173 N Mary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 1 1929
20 UNDERTAKER Virginia G. Brooks	ADDRESS 1437 Pa.

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49671

CERTIFICATE OF DEATH.

74-001

E 49671

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lewis W. Duke

(a) RESIDENCE NO. 2626 Garrett Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va.

PARENTS

10 NAME OF FATHER John W. Duke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary E. Compton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Samuel G. Duke

(Address) 2626 Garrett Ave.

15 Filed OCT 1 - 1929. 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

18 DATE OF DEATH (month, day, and year) Sept 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Coml (Signed) M. D.

(Coroner)

, 19 27 (Address) 1639 Bruning

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., one day ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Front Royal Va - Via Penn RR. Date of Burial Oct 1 1929

20 UNDERTAKER John F Denny ADDRESS 715 Light St

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49672

CERTIFICATE OF DEATH

74-001

REGISTERED NO. E 49672

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 923 W. 38 St. (ST.) 13-5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella S Shock

(a) RESIDENCE NO. 923 W. 38 St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced
If ~~HUSBAND~~ of
(or) WIFE of: John A Shock.

6 DATE OF BIRTH (month, day, and year): April 11- 1855

7 AGE: Years 79 | Months 4 | Days 18 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Ezekiel Whitcomb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Eleanor McGuloth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mr. Shock
(Address): 923 W. 38 st

15 Filed 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29-29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1929, to Sept. 29, 1929, that I last saw h— alive on Sept. 29, 1929 and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank H Lynch, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Gardens DATE OF BURIAL: Oct 2 1929

20 UNDERTAKER: A S Marshall ADDRESS: 3539 Falls Road

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49673

E 49673

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3300 Archentrolly Terrace Ward) 48-59

2-FULL NAME Harry Orarksky

(a) RESIDENCE NO. 3300 Archentrolly St., Terrace Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	27	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Asreal Oransky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Deitz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Aaron Deitz
(Address) 3300 Archentrolly Terrace

15 Filed ..... 19.... HAMPSON JONES, M. D. Registrar.

OCT 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Vascular Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Thomsen M. D.

9/30. 1929 (Address) 3032 Rolandene

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Rd	10/1 19 29

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 49674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 E 49674

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3608 Hinchie Rd ST. 25-42 WARD)

2-FULL NAME Samuel P. Kelley.

(a) RESIDENCE NO. 3608 Hinchie Rd. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida C. Kelley.

6 DATE OF BIRTH (month, day, and year) April 10/1861.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68.	5.	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea food. dealer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Employed.

9 BIRTHPLACE (city or town) (State or country) Laurel. Md.

PARENTS

10 NAME OF FATHER William Kelley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah E. Kelley. (Address) 3608 Hinchie Rd

15 Filed 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29/ 1929.

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1929, to Sept 29, 1929, that I last saw him alive on Sept 29, 1929, and that death occurred, on the date stated above, at 6 30 P m

The CAUSE OF DEATH* was as follows:

Acute Glomerulonephritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) F. T. Kyper, M. D.

9/30/1929 (Address) 3321 Fleetwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cem Hampden

DATE OF BURIAL Oct 2, 1929

UNDERTAKER Hall Bros

ADDRESS 330 Bond St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49675

CERTIFICATE OF DEATH

129

E 49675

1-PLACE OF DEATH

City of Baltimore: (No. 532 W Hoffman 17-24 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lenah Sales.

(a) RESIDENCE No. 532 W Hoffman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Edmund Sales.

6 DATE OF BIRTH (month, day and year): 1885

7 AGE: Years 44; Months; Days; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co (State or country) Md

PARENTS

10 NAME OF FATHER: Henry Gibbs

11 BIRTHPLACE OF FATHER (city or town) Howard (State or country) Md.

12 MAIDEN NAME OF MOTHER: Martha

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md.

14 Informant: Edmund Sales
(Address) 532 W Hoffman

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.
Registrar

CT 1 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 28th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ..... death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) Ruth Ackerman, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 1st 19

20 UNDERTAKER: H. L. Jones — ADDRESS: 111 S. Gilmor

Important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—600 Bks.

229197

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49676

CERTIFICATE OF DEATH

101-001

E 49676

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Kellough

(a) RESIDENCE NO. 1205 N Milton ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 4/12/62

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Kellough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Reads

(Address) JOHNS HOPKINS HOSPITAL

Filed OCT 1 - 1929 C. HAMPSON JONES, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-30-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept-15, 1929, to Sept-30, 1929, that I last saw h.i.m alive on Sept-30, 1929 and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Sept 24, 29

Was there an autopsy? Yes Removal of Gall Bladder

What test confirmed diagnosis? Autopsy

(Signed) J H Campbell, M. D.

9/30, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 2 1929
20 UNDERTAKER	ADDRESS
Robert Boorheem	Calhoun & Collins

Spec.—2-29-28—L. F. S.—500 Blks.

E 49677 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 E 49677

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1515 N Mulberry ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jamie Offer

(a) RESIDENCE NO. 1515 N Mulberry ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or ~~Divorced~~, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 12-1900

7 AGE: Years 29 | Months 5 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private family

(c) Name of employer: Same

9 BIRTHPLACE (city or town) (State or country): Charleston, Md

10 NAME OF FATHER: Wm Offer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charleston Md

12 MAIDEN NAME OF MOTHER: Elizabeth Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hagerstown Md

14 Informant: Mrs. Carrie E. Augustus

(Address): 1515 W. Mulberry

Filed OCT 1 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/27/29

17 I HEREBY CERTIFY, That I attended deceased from 9/26, 1929, to 9/27, 1929, that I last saw h[er] alive on 9/27, 1929 and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

I Pontal Hemorrhage Fatal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. E. Bell, M. D.

, 19 (Address) 918 N Grmdon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int. Auburn Cemetery

20 UNDERTAKER: Wm. Kate R. Williams

DATE OF BURIAL: Oct 1, 1929

ADDRESS: 325 N Schroeder St

Spec.–7-17-26—A Co.—200 Bks.

E 49678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 49678

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 27 E. Heath St. 23-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia A. Skelton

(a) RESIDENCE NO. 27 E. Heath St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 23 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) April, 6, 1929.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
		5,	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER James R. Skelton

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Catherine I. Kyle.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Catherine I. Kyle.

(Address) 27 E. Heath St.

15 Filed OCT 1 - 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 / 29 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Sept 29, 1929, that I last saw h. alive on Sept 29, 1929, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis - Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. H. Campbell, M. D.

29/29 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Oct 1, 1929

UNDERTAKER A. Howard Evans ADDRESS 258 Fortan

very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Israel Title

E 49679 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49679

21

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 5-8 WARD)

2-FULL NAME Israel Title

(a) RESIDENCE NO. 1209 St Matthews ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1920

7 AGE: Years 8 | Months 5 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) School
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Simon Title

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sophie Fortes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto

15 Filed 1929, 19 C. HAMPSON JONES, Registrar M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-16, 1929, to 9-30, 1929.
that I last saw him alive on 9-30, 1929
and that death occurred, on the date stated above, at 940 P m.
The CAUSE OF DEATH* was as follows:
Empipelas

(duration) yrs. mos 14 ds 15

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home ?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) Edmund Cohen M. D.
9/30 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Memorial — DATE OF BURIAL 10/1 1929

20 UNDERTAKER: Jack Lewis — ADDRESS 1439 E Balto

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49680

CERTIFICATE OF DEATH.

74-001

E 49680

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Johns Hopkins Hospital St. 27 53 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Turner Tongue

(a) RESIDENCE NO. 702 Belvedere Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Van Arsdale Tongue

6 DATE OF BIRTH (month, day, and year) May 25, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer T. T. Tongue & So.

9 BIRTHPLACE (city or town) Anne Arundel County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas T. Tongue

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Tabb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mr. Benjamin Tongue

(Address) 700 Belvedere Ave.

Filed T 1 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 30 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Apoplexy-Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) John H. Cullen M. D.

(Coroner)

9/30/29 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial Oct. 2 19 29

20 UNDERTAKER Joseph S. Cook ADDRESS 1003 West Baltimore St.

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

19681

161-002

CERTIFICATE OF DEATH

E 19681

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 N. Highland ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Coldewey

(a) RESIDENCE NO. 630 N. Highland ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Coldewey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Dorothy Regan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant George Coldewey
(Address) 630 N. Highland Ave

15 Filed OCT 1 - 1929 E. J. JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Sept 30, 1929, that I last saw h. alive on Sept 30, 1929 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Prolonged Birth
Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Francis B. Talbot, M. D.

9/30, 1929 (Address) 311 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Oct 1 1929
20 UNDERTAKER	ADDRESS
M. W. E. Dyer & Son	37 S. Ann

Spec.-7-17-26—A Co.—200 Bks.

E 49682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 49682 REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home

City of BALTIMORE: (No. 1404 W Lexington St. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances R Day

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22 1835

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	94	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Martha E Baker

(Address) 1404 W Lexington

15 1929 16 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1927 to October 1 1929

that I last saw h.. alive on Sept 15 1929

and that death occurred, on the date stated above, at 3'5 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin C Jarrett M. D.

, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Belair Md — Date of Burial Oct 3 1929

20 UNDERTAKER Geo J Smith — ADDRESS 532 Hollins

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49683

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49683

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital 6-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William McGowan

(a) RESIDENCE NO. 124 S. Clinton ST. 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs 10 mos 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 13, 1924

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
4	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child —

(b) General nature of industry, business, or establishment in which employed (or employer): Home —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Custis J. McGowan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Anna Jacholka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Anna McGowan

(Address) 124 S. Clinton St —

15 FILED OCT 1 - 1929 HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29/1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Sept 29, 1929, that I last saw h in alive on Sept 28, 1929 and that death occurred, on the date stated above, at 2 45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Meninges (Meningitis)

(duration) 0 yrs. 0 mos. 20 ds.

CONTRIBUTORY (Secondary): None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 124 S. Clinton St —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical findings & Spinal puncture

(Signed) Addison Craft Tilly M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Oct 2nd 1929
20 UNDERTAKER: Lilly & Zeiler Inc	ADDRESS: 4030 Woodland

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49684

CERTIFICATE OF DEATH

74-09

E 49684

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5007 O. Donnell ST., 26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Zebelein

(a) RESIDENCE NO. 5007 O. Donnell ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 10th 1858

7 AGE: Years 71 | Months 4 | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Retired.

(a) Trade, profession or particular kind of work: R. R. Employee.

(b) General nature of industry, business, or establishment in which employed (or employer): 073

(c) Name of employer: Penna R. R.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Zeberlein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie Steele.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Zellinger

(Address) 5007 O. Donnell St.

15 Filed 1 1929, 19 [illegible] HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 29/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 29, to Sept 29, 19 29

that I last saw h.... alive on Sept 27, 19 29

and that death occurred, on the date stated above, at 10 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Amacelli Tetrow, M. D.

9/30. 1929 (Address) 31 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemet	Oct 2nd 1929
20 UNDERTAKER	ADDRESS
Lilly + Gilbert Inc	1030 c. Myrtle Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 49685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49685

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 505 N. Fremont Ave. ST. 17-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Kennedy

(a) RESIDENCE NO. 505 N. Fremont Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma F. Kennedy (nee Hipkins)

6 DATE OF BIRTH (month, day, and year) Aug. 6, 1861.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer) 163

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Daniel Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Allen Conly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Emma F. Kennedy,

(Address) 505 N. Fremont Ave.

15 Filed - 1929 C. HAMPSON JONES, M. D. Registrar. By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 15th, 1929, to Sept 29, 1929, that I last saw h. alive on Sept 29, 1929 and that death occurred, on the date stated above, at 10 15/a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Chronic Nephritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J Murray M. D.

9-30, 1929 (Address) 510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct. 2 1929
20 UNDERTAKER Harry V. Wagner	ADDRESS 531 W. Lombard St

Spec.—2-29-28—L. F. S.—500 Bks.

E ~~49~~ 49686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 49686

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christina Hartman

(a) RESIDENCE NO. 1405 N. Rose ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-12-29

7 AGE — Years: — Months: 2 — Days: 16 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nicolas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Ostertage

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 1 1929 19 Per HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Sept 28, 1929, that I last saw her alive on Sept 28, 1929 and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Entero-colitis

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Benj. E. Hodge, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

UNDERTAKER

ADDRESS

DATE OF BURIAL OCT 1 1929

Spec.—2-29-28—L. F. S.—600 Bks.

E 49637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 49637

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M Lang

(a) RESIDENCE NO. 104 S. Dean ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-8-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Joseph Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Anna Bluhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

PARENTS

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 3934 JOHNS

SEP - 1929 G. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1929, to Sept 26, 1929, that I last saw her alive on Sept 26, 1929 and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Dermatitis Exfoliativa

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Burkholder M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL OCT 1 19 1929

20 UNDERTAKER

ADDRESS

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49688

CERTIFICATE OF DEATH.

E 49688

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital WARD) 124 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Scott

(a) RESIDENCE No. 300 Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Seattle Wash.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant friend

(Address) UNIVERSITY OF MARYLAND

15 Filed OCT 1 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Sept 30, 1929.

that I last saw h(m) alive on Sept 30, 1929

and that death occurred, on the date stated above, at 9 55 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Cause unknown)

(duration) yrs. mos

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Grouping of blood.

(Signed) George McDonald M. D.

, 19 (Address) Provident Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL OCT 1 19 1929

20 UNDERTAKER [illegible] Austin.

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49639

CERTIFICATE OF DEATH

188-183

E 49639

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hosp St., 20-69 Ward)

2-FULL NAME Joseph C. Rivers

(a) RESIDENCE NO. 2328 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Bell Rivers

6 DATE OF BIRTH (month, day, and year) Jan - 1st - 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	31	8	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer) Balto City
(c) Name of employer same

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jos C Rivers

11 BIRTHPLACE OF FATHER (city or town) ~~Balto~~ Newark
(State or country) ~~Md~~

12 MAIDEN NAME OF MOTHER Eliz Whalen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Joseph C Rivers
(Address) 2328 W. Fayette st

15 Filed - 1929 C. HAMPSON JONES, M. D. Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Thrombi
secondary to an appendectomy
that was preceded by an accident
occurring while in line of
CONTRIBUTORY (Secondary) duty (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fremont & Bare
Did an operation precede death? Yes Date of 9-24-29
Was there an autopsy? Yes
What test confirmed diagnosis? Path.
(Signed) H. J. Plume M. D.
10/1 1929 (Address) 2939 McElderry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 2nd 1929
20 UNDERTAKER	ADDRESS 623
L. Lawson Kennard	N. Libert St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 49690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

160 E 49690

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 516 E 27th ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Arthur Doyle

(a) RESIDENCE NO. 516 E 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 6. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John C Doyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Florence Lumbacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John C Doyle

(Address) 516 E 27th St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23rd, 19 29, to Sept 30th, 19 29, that I last saw h[illegible] alive on Sept 30th, 19 29 and that death occurred, on the date stated above, at 6 20P m.

The CAUSE OF DEATH* was as follows:

Acute Inanition

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Diet

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) [illegible] M. D.

10/1/29 (Address) 516 E 27th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine Grove	10/2 19 29
20 UNDERTAKER	ADDRESS
Wm Cook	1217 E Pratt St

Cor.—10-10-29—A Co.—100 Bks.

E 49691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

196 ✓ E 49691

REGISTERED NO. 23-34

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Meyers.

(a) RESIDENCE NO. 1622 Elkins Lane. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, HUSBAND of Catherine Meyers

6 DATE OF BIRTH (month, day, and year) March 28, 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	32	6	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Crain operator.
(b) General nature of industry, business, or establishment in which employed (or employer) B. Md. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER John H. Meyers.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Cunningham.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant John Meyers. (father)
(Address) 1426 Marshall St.

15 Dated ..., 1929 16 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 29, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocution and fracture of skull Coming in contact with electric wire and fall of 25 feet. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Port Covington Sep. 29, 1929

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Kunnardt, M. D.

10/1. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	10/2 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St. Paul St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49692

E 49692

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Enroute St. Joseph Hospital St., Ward)

2-FULL NAME John Turner

(a) RESIDENCE NO. 1239 N. Bond St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13/1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	2	2	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Hernan C. Turner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Phila., Pa.

12 MAIDEN NAME OF MOTHER T. Galonis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Hernan C. Turner
(Address) 1239 N. Bond St

15 Filed 2 1929 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 30/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & other injuries Accidently struck & run over by street car on Preston St bet Bond & Caroline Sts (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)
(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

9-1-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	10/2 1929

20 UNDERTAKER George J Ruth ADDRESS 1735 Hartford Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49693

CERTIFICATE OF DEATH

127 E 49693

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 211 S Dunbar St., 2-4 Ward)

2-FULL NAME Alvis Meyers

(a) RESIDENCE NO. 211 S Dunbar St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col	Single

5a If married, widnwed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. nr min.
	About 35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant George Williams
(Address) 211 S Dunbar St

Filed OCT 2 - 1929 HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By Gross & Clinical

(Signed) [illegible] M. D.

Oct 1, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	10/3 1929
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Harford Ave

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49694 **CERTIFICATE OF DEATH.** 161-001 E 49694

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST., 1724 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Timms

(a) RESIDENCE NO. 611 Brown St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 19 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. 40 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joshua Timms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Watersville Md.

12 MAIDEN NAME OF MOTHER Estelle S. Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt. Airy Md.

14 Informant (Address)

15 Filed 12 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 .1929. to Sept 19 .1929 that I last saw h(e) alive on Sept 19 .1929 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Premature infant
Twin #1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Thos H Douglass, M. D.

(Address) Mun. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 1/19

20 UNDERTAKER C. HAMPSON JONES & SON M. D.

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49695

CERTIFICATE OF DEATH.

161-001

E 49695

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST. 17-27 WARD)

2-FULL NAME Baby Girl Simms

(a) RESIDENCE NO. — ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1929

7 AGE	Years	Months	Days	If LESS than 1 day 3 hrs or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profesion or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joshua Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Waterville Md.

12 MAIDEN NAME OF MOTHER Estelle S. Troy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mt. Airy, Md.

2 - 1929

Informant

(Address)

15 Filed 2 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1929 to Sept. 19, 1929.

that I last saw her alive on Sept. 19, 1929

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Infant premature
(Twin #1)

(duration) — yrs. — mos. — da.

CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

(Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

UNIVERSITY OF MARYLAND

DATE OF BURIAL Sept 1 1929

20 UNDERTAKER

Commissioner Health

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

Shaum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49696

CERTIFICATE OF DEATH

161-091

E 49696

1—PLACE OF DEATH St Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & other ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby girl Shaum

(a) RESIDENCE NO. Janeytown ST. 2nd. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: F | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Sept 30, 1929

AGE	Years	Months	Days	If LESS than 1 day, Hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Joseph's Hospital
(State or country)

10 NAME OF FATHER Bernard Shaum

11 BIRTHPLACE OF FATHER (city or town) Janeytown Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Sanders

13 BIRTHPLACE OF MOTHER (city or town) Ba
(State or country)

14 Informant Hospital Records
(Address)

15 Filed 2-1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-1-29.

17 I HEREBY CERTIFY, That I attended deceased from 10-1-29, 19, to 10-1-29, 19,

that I last saw h alive on 10-1-29, 19

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Prematurity

What test confirmed diagnosis?

(Signed) W H Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's Janeytown	Oct 2 1929
20 UNDERTAKER E D Susat Son	ADDRESS Janeytown Md

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49697

CERTIFICATE OF DEATH.

12 9 E 49697

REGISTERED NO. 2440

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 Dolphin st St. 17-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward Williams

(a) RESIDENCE NO. 607 Dolphin St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 7 mos. 24 dys. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Williams

6 DATE OF BIRTH (month, day, and year): March 5 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER James Benj. Williams

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country) Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto Md

14 Informant: Annie Williams

(Address) 607 Dolphin St

15 Filed OCT 2 - 1929, 19 HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1926, to Sept 29, 1929, that I last saw him alive on Sept 28, 1929, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease and Chronic nephritis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Wm H. Watts, M. D.

, 19 (Address) 928 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem Date of Burial Oct 3 1929

UNDERTAKER: Samuel F. Greenley & Bro ADDRESS 928

Key Diagram. See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49698

CERTIFICATE OF DEATH

E 49698

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1017 Brantley Ave (STREET) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Belle May Bacon

(a) RESIDENCE NO. 1017 Brantley Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 14 1879

7 AGE — Years: | Months: | Days: 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Robert Bacon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ethel Bowser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

PARENTS

14 Informant: Ethel Bacon

(Address) 1017 Brantley Ave

15 Filed 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/29/29

17

I HEREBY CERTIFY, That I attended deceased from 9/17, 1929, to 9/29, 1929, that I last saw her alive on 9/29, 1929, and that death occurred, on the date stated above, at 5-55 a.m.

The CAUSE OF DEATH* was as follows:

Premature Delivery —

6½ Pregnancy — 1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? NW

Did an operation precede death? NW Date of

Was there an autopsy? none

What test confirmed diagnosis? none

(Signed) Dan Grandeau M. D.

9/30, 1929 (Address) 124 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn Cem

DATE OF BURIAL: 10-3-29

20 UNDERTAKER: Samuel Hensley

ADDRESS: Belle

Spec.—2-29-28—L. F. S.—500 Blks.

49699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 49699

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2035 Sinclair Lane ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Jahn

(a) RESIDENCE NO. 2035 Sinclair Lane ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Otto G. Jahn

DATE OF BIRTH (month, day, and year) Dec 11/70

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	19	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER John P. Kessler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Catherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

Informant Otto G. Jahn

(Address) 2035 Sinclair Lane

Filed ... 19 ... Registrar

7 - 1929 HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30/29

17

I HEREBY CERTIFY, That I attended deceased from Mch 17, 1927, to Sept 30, 1929, that I last saw h alive on Sept 29, 1929 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration Patient Patients Died Sunday

CONTRIBUTORY (Secondary) Chron Nephritis (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Lemmon M. D.

9/30/29 (Address) 7182 Pulaski Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem. Canton	Oct. 2 1929
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Bks.

49700 35 1 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 46 ✓ E 49700

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Faulcon

(a) RESIDENCE NO. Severna Park Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Archer

DATE OF BIRTH (month, day, and year) 1-28-1907

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	8	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W - 097

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Cath Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 2 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28-1929

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1929, to Sept 28, 1929, that I last saw her alive on Sept 28, 1929 and that death occurred, on the date stated above, at 540 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovaries.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 19-9-1929.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. G. Douglas, M. D.

, 19 (Address) J-H-H-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Town Neck cemetery	Oct 31 1929
20 UNDERTAKER	ADDRESS
Chas E Fickes Jr	Severna Park Md

Cor.—12-9-25—A Co.—200 Blks.

E 49701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5-9-74-001

E 49701

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1409 Mulliken St. 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbra Whitley

(a) RESIDENCE NO. 1409 Mulliken St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Whitley

6 DATE OF BIRTH (month, day, and year) Sept 19 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER John Arthur

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Hattie Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Chas Whitley

(Address) 1409 Mulliken St

15 Filed OCT 2 - 1929 E. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Sep 29/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.

(Coroner)

10/2/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Date of Burial Oct 2 1929

20 UNDERTAKER Mrs R. A. Elliott ADDRESS 1725 Ashland ave

Very Important. See instructions on back of Certificate.

Spec.—1 12-23—MAT—500 Blks.

E 49702 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 49702

74001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 N. Carey St., 16-23 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Johnson

(a) RESIDENCE NO. 1025 N. Carey ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct. 5-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore Copper Works

PARENTS

9 BIRTHPLACE (city or town) Jamaica (State or country) West Indies

10 NAME OF FATHER Charles Johnson

11 BIRTHPLACE OF FATHER (city or town) West Indies (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) West Indies (State or country)

14 Informant Burleah Johnson (Address) 1025 N. Carey St

15 [illegible] 12 - 1929 C. HAMPSON JONES, M. D. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Sept 29, 1929, that I last saw h[illegible] alive on Sept 28, 1929 and that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (2nd attack), 18 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Copper Works

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H. Wright, M. D.

Sept. 29 1929 (Address) 1209 Druid Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 2nd 1929
20 UNDERTAKER	ADDRESS
Thomas E Kelson	1303 Pres[illegible]

Spec.—1-12-23—M&T—500 Blks.

E 49703 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49703

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 W. North Ave St., 12 WARD) 15-21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eliza A. Thompson

(a) RESIDENCE NO. 2043 W North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Chas. F. W. Thompson

6 DATE OF BIRTH (month, day, and year) June 4-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Minnie Thompson (Address) 2043 W North Ave

15 Filed 2-1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1928, to Sept 30, 1929, that I last saw h er alive on Sept 30, 1929, and that death occurred, on the date stated above, at 10.40 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Geo. B. Shannon, M. D.

10/1, 1929 (Address) 700 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive	Oct 3 1929
UNDERTAKER	ADDRESS
Jeremiah Dyer	1600 W North Ave

Cor.—10-10-29—A Co.—100 Bks.

49704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49704

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W. Norr

(a) RESIDENCE NO. 205 N. Ellwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie E. Norr

6 DATE OF BIRTH (month, day, and year) Nov 26/1880

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	48	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. Police Dept

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER William Norr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Lemature

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mamie E. Norr (Wife)
(Address) 205 N. Ellwood Ave M.

15 Filed 2-1929 HAMILTON BUREAU

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 28/192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

10/1/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Oct 2 1929

20 UNDERTAKER Lilly & Zeiler inc

ADDRESS 4038 Wolfe St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49705 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

9/16 159-001

E 49705

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2421 E. Lafayette St. Ave WARD)

2—FULL NAME Baby Markell

(a) RESIDENCE NO. 2421 E. Lafayette ST., Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): —

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct 1, 1929

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 20 min.
	—	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER Vincent Markell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Marie E. Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Vincent Markell

(Address) 2421 E Lafayette St.

Filed ..... 1929 HARRISON JONES, M. D. Registrar

T 2 - 152 Pat.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, to Oct 1st, 1929, that I last saw her alive on Oct 1st, 1929 and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. L. Dalaglisaca, M. D.

, 19 (Address) 1117 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem — DATE OF BURIAL: Oct 2nd 1929

20 UNDERTAKER: Leo S. Cook — ADDRESS: 1725 Patt. Pk Ave

Cor.—10-10-29—A Co.—160 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49706

CERTIFICATE OF DEATH

1928 E 49706

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Johns Hopkins Hospital St., 8-12 Ward)

2-FULL NAME Henry A. Stek

(a) RESIDENCE NO. 2322 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Stek

6 DATE OF BIRTH (month, day, and year) Dec 20/1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pipe-Fitter
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Water Dept
(c) Name of employer Balto., City

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Bernard Stek

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Stek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Catherine Stek
(Address) 2322 E. Chase St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar
1928 per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, hrld an Inquiry (Inquest, Autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to h i s death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock-Hemorrhage-Multiple Wounds on Head, face & neck. Amputation of penis, excision of rt testicle (Probably "onicide)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contrarted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/2/29 (Address) 308 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 3 1929
20 UNDERTAKER George W. Zirkle	ADDRESS 1737 E Eager St

Spec.—2-29-28—L. F. S.—500 Blks.

E 49707 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 ✓ E 49707

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bs Balto. Gen Hosp ST. 23-3K WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Thompson

(a) RESIDENCE NO. 1515 Race St ST., WARD 6
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 2 mos. 20 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 11, 1922

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7 yrs	2	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mamie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr John Thompson
(Address) 1515 Race St.

15 Filed 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-1-29

17 I HEREBY CERTIFY, That I attended deceased from 9/26-29, 19 to 10/1, 19 29.

that I last saw h[illegible] alive on October 1, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of mandible
Septicemia Tuberculosis
Lep

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia Tuberculosis, Septic
Bilateral Broncho Pneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home (Balto)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) E. A. Liberger, M. D.

19 (Address) c/o Balt Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	10/4 1929
20 UNDERTAKER J. F. McCully	ADDRESS 130 E. Fort

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49708 E 49708

CERTIFICATE OF DEATH

REGISTERED NO. 100-001

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4-7 WARD)

2—FULL NAME John Wm Mediary

(a) RESIDENCE NO. Owings Mills, Md ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6. ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX M / Masculine | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 25, 1929

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	6.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER George C. Mediary

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Hilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George C. Mediary (Address) Owings Mills Md

15 Filed ..... 1929 (HAMPSON JONES, M. D.) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1929, to Oct 1, 1929.

that I last saw h. alive on Oct 1, 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy.

(Signed) J Leyko, M. D.

10/2 1929 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hartford Rd Holy Cross Cemetery

DATE OF BURIAL Oct 4 1929

20 UNDERTAKER J. F. Edwin Funeral Home

ADDRESS 1111

Spec.—2-29-28—L. F. S.—500 Bks.

E 49709 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49709

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Mackert

(a) RESIDENCE NO. 1415 Eastern Ave. ST., WARD 6
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ?mos. ?ds. How long in U. S., If foreign birth? —yrs. —mos. —ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) 11/21/1866 Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62 63	10	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~ Potter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ?

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Conrad Mackert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Records of

(Address) Balto. City Hospitals

Filed OCT 2 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 11, 1929 to Sept. 27, 1929 that I last saw him alive on Sept. 27, 1929 and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Facute

(duration) 3? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Path. Lab

(Signed) Warren H. McTeer, M. D.

, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 10/1/29

20 UNDERTAKER George Wolff

ADDRESS 135 Hanover

Spec—12-23-21—E.B.R.S.—400 Bks.

Clayton Johnson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49710

CERTIFICATE OF DEATH.

113 E 49710

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1537 Orleans St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clayton Johnson

(a) Residence No. 1537 Orleans St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 21-1929

7-AGE. ....yrs. 6 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, Clayton Johnson

11-BIRTHPLACE OF FATHER (city or town)... Baltimore (State or Country), Md

12-MAIDEN NAME OF MOTHER, Dorothy Parsley

13-BIRTHPLACE OF MOTHER (city or town) Princess Anne (State or Country), Md

14-

(Informant) Dorothy Johnson

(Address) 1537 Orleans St

15-Filed 2 1929 CHAMPION JONES, M. D. 19

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 1-1929

17- I HEREBY CERTIFY, That I attended deceased from Sept 28 1929 to Oct 1 1929

that I last saw h[im] alive on Sept 28 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Undernourished

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas M. D.

, 19 (Address) 822 Aisquith St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Asbury Cem. DATE OF BURIAL. Oct. 3 1929

20-UNDERTAKER. Mrs J. G. Locke ADDRESS 1302 Jefferson

Spec.—2-29-28—L. F. S.—500 Blks.

1

E 4971I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

78 E 4971I

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2856 W. Mulberry St ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Howard Eney

(a) RESIDENCE NO. 2856 W. Mulberry St ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 2 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Carolyn May Eney(nee Brown)

DATE OF BIRTH (month, day, and year) July 2,1901.

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	2	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Liggett & Meyers

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER George W. Eney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence E. Mallonee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

4 Informant Mrs. George W. Eney

(Address) 2856 W. Mulberry St.

5 Filed 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29-29

17

I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Sept 29, 1929.

that I last saw him alive on Sept 29, 1929

and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

Suddenly

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W Bowman Stone M. D.

19 (Address) 626 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct 2 / 19 29

UNDERTAKER Harry A. Wittstadt

ADDRESS 153 W. Lombard St

Spec[illegible]—M&T—1500 Bks. 3204 Georgnes Falls Parkway

E 49712

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49712

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Maryland General Hospital ST., 16-67 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Quirk Merryman

(a) RESIDENCE No. 3204 Gynnsfelk Pkwy ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 53 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Mr. Merryman

6 DATE OF BIRTH (month, day, and year) May 1st. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS
10 NAME OF FATHER Matthew Quirk
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.
12 MAIDEN NAME OF MOTHER Jane Kuhe
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14
Informant
(Address) Hospital records

Filed [illegible] 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1 1929

17
I HEREBY CERTIFY, That I attended deceased from 9/30 1929, to 10/1 1929.
that I last saw her alive on 10/1 1929.
and that death occurred, on the date stated above, at 7:26 P.M.
The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos 10 ds.
CONTRIBUTORY (Secondary) Cardiac failure
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Jas A Thompson M. D.
(Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct. 3 1929
UNDERTAKER Harry N. Wiltse	ADDRESS 1531 W. Lombard

Spec.—2-29-28—L. F. S.—500 Blks.

E 49713 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49713

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 18-76 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Chase

(a) RESIDENCE NO. 917 W. Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mable Chase

DATE OF BIRTH (month, day, and year) ?

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 87

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

BIRTHPLACE (city or town) (State or country) ? Md.

10 NAME OF FATHER Solomon Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Emma Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

Informant Records of

(Address) BALTIMORE CITY HOSPITALS

Filed 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-27-29

17 I HEREBY CERTIFY, That I attended deceased from 9-1, 1929, to 9-27, 1929

that I last saw him alive on 9-27, 1929

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

1. Endocarditis, Chronic Focal

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. C.C. Lab. X-ray

(Signed) Warren W. McLeans M. D.

9-28, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 2, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 3229 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49714 90 E 49714

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Janie Lemons

(a) RESIDENCE NO. 302 S. Fremont Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

3 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) South Carolina

10 NAME OF FATHER Morris Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Lizzie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

Informant Records of
(Address) Baltimore City Hospitals

Filed 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1929 to Sept. 29, 1929

that I last saw her alive on Sept. 29, 1929

and that death occurred, on the date stated above, at 2:40 PM.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Diffuse
(Rheumatic)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & P.E.

(Signed) Marvin M. McLean, M. D.

9-30, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cemetery	Oct 3, 1929
20 UNDERTAKER Mrs Katie R Williams	ADDRESS 2224 Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49715

CERTIFICATE OF DEATH

129 ✓ E 49715

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3302 Devonshire Drive ST., 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosanna Mentzel,

(a) RESIDENCE NO. 3302 Devonshire Drive ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander C. Mentzel,

DATE OF BIRTH (month, day, and year) August 7. 1852

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	1	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Thomas Mc Cusker,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Catherine Ball,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Mrs Mollie C. Howard,

(Address) 3302 Devonshire Drive

OCT 1 - 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1. 1928 to Oct. 1. 1929.

that I last saw her alive on Oct -1. 1929

and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Chronic Nephritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James B. Aisenbrandt M. D.

10-X. 1929 Address 3012 Park Heights ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Baltimore	
20 UNDERTAKER Geo W Little	ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49716

CERTIFICATE OF DEATH.

90 E 49716

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Enroute fron Sinai Hospital on St. Car 9-13 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME LEWIS HOCHHEIMER

(a) RESIDENCE NO. Sinai Aged Home St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Rev. Henry Hochheimer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not Known

14 Informant Mr. Himmer (No relation)

(Address) Munsey Bldg. Baltimore

15 Filed C. HAMPSON JONES, M. D. Registrar

OCT - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis-Arterio-sclerosis (duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

10/2/29 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cemetery — Date of Burial: Oct. 4 1929

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: BALTIMORE ST. & BROADWAY.

Cor.—10-10-29—A Co.—100 Bks.

E 49717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49717

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3110 Foster St., W Ward)

2-FULL NAME Caroline D Mitchell

(a) RESIDENCE NO. 3110 Foster St., / Ward Mo.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Otis Mitchell

6 DATE OF BIRTH (month, day, and year) Feb 19th 1879

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
50	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)
(r) Name of employer

9 BIRTHPLACE (city or town) Revere Mass.
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) U S
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) U S
(State or country)

14 Informant Annie Amend
(Address) 3110 Foster Ave

15 Filed OCT 3 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Phy. History

What test confirmed diagnosis?

(Signed) H C Yates, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Oct 4 1929
20 UNDERTAKER	ADDRESS
Lilly + Gaither Inc	403 N. Wolfe

IMPORTANT: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49718

37-001

E 49718

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2030 E Pratt St. 2-4 Ward)

2-FULL NAME Dorothy May Miller

(a) RESIDENCE NO. 2030 E Pratt St., 2 Ward

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 2nd 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	—	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Edw. Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Edith Bruett

13 BIRTHPLACE OF MOTHER (city or town) Conn.
(State or country)

14 Informant Edw. Miller
(Address) 2030 E Pratt St

Filed OCT 3 - 1929

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1- 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

I B- Miliary

(duration) — mos. 1 da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. 1 da.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By History

(Signed) Thos. E. Hughes, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct 5 1929
20 UNDERTAKER	ADDRESS
J. Lilly - Jule Inc	405 S. Wolfe

Important: See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Blks.

E 49719 HEALTH DEPARTMENT—CITY OF BALTIMORE

143-003

E 49719

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dora Griffin.

(a) RESIDENCE No. 2113 Ramsay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Thomas J Griffin

6 DATE OF BIRTH (month, day, and year) Feb 20 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas Md

12 MAIDEN NAME OF MOTHER Mary Redelth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Edward L Nash 207 Florence Ave

15 Filed 10/2 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/24 1929 to 10/2 1929.

that I last saw her alive on 10/2 1929

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Toxic vomiting of Pregnancy (duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Emb R Kemp Jr M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 4 1929
20 UNDERTAKER	ADDRESS
Robert Brookeson	Calhoun Hoffman's

Cor.—10-10-29—A Co.—100 Bks.

E 49720

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49720

CERTIFICATE OF DEATH

74501

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 8-12 Ward)

2-FULL NAME Norman C. Geiselmann

(a) RESIDENCE NO. 1127 N. Bradford St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2/1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47	4 3	C 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Penna

PARENTS

10 NAME OF FATHER Norman Geidman

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Penna

12 MAIDEN NAME OF MOTHER Marion Turner

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Edward C. Belitski
(Address) 1127 N. Bradford St

15 Filed ....., 19.... C. HAMPTON JONES, M. D. Registrar

OCT 3 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? At Hopkins Hospital

What test confirmed diagnosis? .....

(Signed) H. C. Hamm, M. D.

10-2-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Oct 5 1929

20 UNDERTAKER Robt Burns

ADDRESS 144 N Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 19721 — 38 — E 19721

1—PLACE OF DEATH: Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST., 47-38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: Nora Green

(a) RESIDENCE NO. 138 W. York ST., ____ WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Green

DATE OF BIRTH (month, day, and year): Unknown

AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	38			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Virginia

10 NAME OF FATHER: William Braxton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Polly Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

Informant: Records of

(Address) Baltimore City Hospitals

Filed 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1929 to Oct. 1, 1929

that I last saw her alive on October 1, 1929

and that death occurred, on the date stated above, at 3:45 A. M.

The CAUSE OF DEATH* was as follows:

Syphilis

Myocarditis, chronic Fatal

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxic insufficiency

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.E. Was

(Signed) Irwin M. McLean, M. D.

10-1, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: Oct 4 1929

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Druid Hill

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49722

E 49722

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 5-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lee Harvell

(a) RESIDENCE NO. 1437 E Fayette St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct 7. 1910

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	11	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Elijah Harvell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Laura Honeycutt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Anna Jackson

(Address) 246 N Mount St

Filed 3 - 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept- 30, 1929, to Oct 1, 1929, that I last saw him alive on Oct 1, 1929 and that death occurred, on the date stated above, at 740 P m.

The CAUSE OF DEATH* was as follows:

Meningococcic Meningitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lumbar puncture

(Signed) Myron E. Tull, M. D.

10/2, 1929 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Ct	Oct 3 - 1929
20 UNDERTAKER	ADDRESS
J. R. Brown's Son	[illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-001

E 49723

1—PLACE OF DEATH

REGISTERED NO. E 49723

CITY OF BALTIMORE: (No. 1813 Thomas Av ST., 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elaine Blackford Robinson

(a) RESIDENCE NO. 1813 Thomas Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 7 mos. 29 ds. How long in U. S., if foreign birth? 0 yrs. 7 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

DATE OF BIRTH (month, day, and year) Feb 2/1929.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	7	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER G. Alvine Robinson

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER J. Ethel Wooden

13 BIRTHPLACE OF MOTHER (city or town) Balto Co.
(State or country) Maryland

Informant Mr. G. A. Robinson (Father)
(Address) 1813 Thomas Ave.

Filed 3 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Oct 1, 1929, that I last saw h[illegible] alive on Oct 1, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Acute Pyelitis - Acute Miliary Tuberculosis (duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edmund B Lennan, M. D.

10/2, 1929 (Address) 718 N Pattison St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct 3/ 1929.
20 UNDERTAKER	ADDRESS
Stewart & Mowen Co.	Balto.

Spec.—2-29-28—L. F. S.—500 Blks.

49724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 49724

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1373 N. Stricker ST. 15-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura E. Martin

(a) RESIDENCE NO. 1373 N. Stricker ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

6 If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Obed J. Martin

DATE OF BIRTH (month, day, and year) Jan 14 77

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lancaster Co Va

10 NAME OF FATHER Erasmus Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elsie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Obed J. Martin

(Address) 1373 N. Stricker St

Filed ..... 19.. HAMPSON JONES, M. D.

By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1926, to Sept 30, 1929, that I last saw h[illegible] alive on Sept 28, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1155 N. Carlton St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thyroid Serum

(Signed) [illegible] M. D.

9/x, 1929 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Oct 3 1929
20 UNDERTAKER	ADDRESS
Jno. H. Chase Son	402 Mosher

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49725

CERTIFICATE OF DEATH

161-001

E 49725

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Ashburton ST., 15-08 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Donald Thomas Bilson

(a) RESIDENCE NO. 1813 Ashburton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 9 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Francis D. Bilson

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country)

12 MAIDEN NAME OF MOTHER Margaret Nuhol

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

Informant Francis D. Bilson

(Address) 1813 Ashburton Ave

Filed 3 - 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Oct 1, 1929, that I last saw h— alive on Oct 1 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Premature Infant

(duration) yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ½ hr

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? ?

What test confirmed diagnosis? Time of Prematurity

(Signed) Walter C Bacon M. D.

10/2 1929 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct 3 1929
UNDERTAKER W. Reeves & Son	ADDRESS North Ave

Cor.—10-10-29—A Co.—100 Bks.

E 49726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49726

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1309 N. Stricker St., 15-22 Ward)

2-FULL NAME Jas. M. Dorsey.

(a) RESIDENCE No. 1309 N. Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie Dorsey

6 DATE OF BIRTH (month, day, and year): May 15-1880

7 AGE: Years 49 | Months 6 | Days 15 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Va.
(State or country)

PARENTS

10 NAME OF FATHER: John H. Dorsey

11 BIRTHPLACE OF FATHER (city or town): Ft. Mumford Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER: Millie Duke

13 BIRTHPLACE OF MOTHER (city or town): Pikesville
(State or country) Md.

14 Informant: Lavinia Brookes.
(Address) 1304 N. Stricker

15 Filed ....., 19..... J. HAMPDEN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Inquiry thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regulus

(Signed) Hebbeler, M. D.

Oct. 1, 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. M. Cemetery — DATE OF BURIAL: Oct 3rd 1929

20 UNDERTAKER: Samuel E. Wright — ADDRESS: 864 Mary

Spec.—8-16-29—L. F. S.—100 Bks.

E 49727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49727

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 2020 Westwood ave ST. 15-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Etta Korman

(a) RESIDENCE NO. 2020 Westwood ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benj Korman

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 64; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Pacus Bouroon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Cuttle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: Israel Korman

(Address) 2020 Westwood ave

Filed 3-1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/2/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Oct 2, 1929, that I last saw h[illegible] alive on Oct 2, 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Ch Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Hornstein, M. D.

10/3, 1929 (Address) 733 Arguth St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nehrem Mt Carmel

DATE OF BURIAL: 10/3 1929

20 UNDERTAKER: Jack Leurs

ADDRESS: 1439 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49728

CERTIFICATE OF DEATH

1558 117

E 49728

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Sarah Mendel

(a) RESIDENCE NO. 4227 Park Heights Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 20-1911

AGE	Years	Months	Days
	18	1	6

If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): 609

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto City Md

10 NAME OF FATHER: Harry Mendel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Ethel Mastbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Harry Mendel

(Address) 4227 Parkheights ave

15 Filed OCT 3 - 1929 [illegible] LAMBERT T. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Oct 2, 1929

that I last saw h alive on Oct 1, 1929

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 9/16 Appendectomy

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) Theo. C. Stacy, Jr. M. D.

10/2, 1929 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Cascade	10/3 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49729

CERTIFICATE OF DEATH

11-001

REGISTERED NO. E 49729

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 E. Biddle ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Engelhardt

(a) RESIDENCE NO. 930 E. Biddle St ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 1 mos. ds. How long in U. S., if foreign birth 37 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna C. Engelhardt

DATE OF BIRTH (month, day, and year) Jan. 28 1868

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	8	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER George Engelhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Miss. Seift.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Anna C. Engelhardt

(Address) 930 E Biddle St

Filed 3-5 1929 HAMPSON JONES M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Oct 1, 1929

that I last saw h~~m~~ alive on Oct 1, 1929

and that death occurred, on the date stated above, at 12 12 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Kelly, M. D.

10/1, 1929 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Oct 4th 1929

20 UNDERTAKER: Henry Hoen & Sons Inc. — ADDRESS: 1301 E Eager St

Cor.—10-10-29—A Co.—100 Blks.

E 49730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001 E 49730

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1113 N. Central Ave St., 10-14 Ward)

2-FULL NAME Elizabeth Tragresser

(a) RESIDENCE NO. 1113 N. Central Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30/1858

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	70	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jacob Tragesser

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Mueller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Charles F. Tewes
(Address) 1113 N. Central Ave

15 Filed 19 1929 [illegible] Registrar

Del

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

10/3-29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 4' 19 29
20 UNDERTAKER Henry Hoeck Sons Inc	ADDRESS 130 E Eager St

Spec.—2-29-28—I. F. S.—500 Blks.

49731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 49731

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 N Bradford ST. 8-12 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Corrigan

(a) RESIDENCE NO. 1207 N. Bradford ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter J. Corrigan

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	-	-	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

10 NAME OF FATHER Wm Migan

11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

PARENTS

14 Informant Peter J. Corrigan

(Address) 1207 N. Bradford

15 Filed - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2-1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to October 2, 1929-

that I last saw h alive on October 1, 1929

and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation, Compensated
Chronic Calculy matous Nephritis
Hypertension

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Uremia

(Signed) Thos. Ja. Stevens, M. D.

10 2, 19 29 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Oct 5 1929

20 UNDERTAKER Henry Hauck Sons Inc — ADDRESS 1301 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

E 49732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1218 Madison Ave., 11-24 Ward)

2-FULL NAME Edward Scott.

(a) RESIDENCE NO. 1218 Madison Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Emma Scott
(Address) 1326 Argyle Ave

15 Filed OCT 3 - 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 1st 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Provident Hosp

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) H. Leo Smith, M. D.

Oct 1 19 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-3 1929
20 UNDERTAKER Dennis Easton	ADDRESS 916 Cathedral

Spec.—2-29-28—L. F. S.—500 Bks.

Smith

E 49733 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49733

CERTIFICATE OF DEATH 46 46

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3700 Hortonia Road ST., 15-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret A. Smith,

(a) RESIDENCE NO. 3700 Hortonia Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Irvin R. Smith

7 DATE OF BIRTH (month, day, and year) Mar. 15, 1875

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	7	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) Phila., Pa.
(State or country)

10 NAME OF FATHER Patrick Campbell

11 BIRTHPLACE OF FATHER (city or town) Penna.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Tendell

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Irvin R. Smith, Husband

(Address) 3700 Hortonia Road.

15 Filed 3 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2nd, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1922, to Oct. 2nd, 1929, that I last saw her alive on Oct. 2nd, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

(Probably Sarcoma)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Malignant toxemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. Fredrick Rempel M. D.

10/3, 1929 (Address) 3310 W. North ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa — DATE OF BURIAL Oct.5.1929

20 UNDERTAKER Hughes & Monahan — ADDRESS 4th & N. Broad

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49734

CERTIFICATE OF DEATH

188-203

E 49734

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. So. Balto. Gen Hosp St., 34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph S. Budzynski

(a) RESIDENCE NO. 728 S. Bond St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 mos. ds. How long in U. S., if of foreign birth? yrs. mos. da

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov 10-1906

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	22	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Deck Hand
(b) General nature of industry, business, or establishment in which employed (or employer) Towing
(c) Name of employer Bala

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Budzynski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Stanislawa Stoda

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Frank Budzynski
(Address) 728 S. Bond St.

15 Filed OCT 3 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract skull
thrown out of auto in which he was riding when it skidded & left road — (duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Surgical, Trauma, & shock — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Church St Bridge
Did an operation precede death? yes Date of 9/30/29
Was there an autopsy? no
What test confirmed diagnosis? operation
(Signed) F J Braun, M. D.
10/2, 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem,	Oct. 4, 1929.
20 UNDERTAKER W J Sadowski	ADDRESS 2215 Pelham Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 49735 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-081 E 49735

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carmella Mancini

(a) RESIDENCE NO. 440 N. Highland Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Baby

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 21 1924

AGE	Years	Months	Days 10 12	If LESS than 1 day, ...hrs. or ....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto City

10 NAME OF FATHER Luigi Mancini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Manfrè

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Luigi Mancini

(Address) 440 N. Highland ave

15 Filed OCT 3 - 1925 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-1-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 19..., to 10-1, 19 29.

that I last saw h... alive on 10-1 19 29

and that death occurred, on the date stated above, at 3 40 A.M.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W B Hundley M. D.

19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Ca.	10/3, 1929
20 UNDERTAKER	ADDRESS
Geo J Ruth	1235 Harford ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49736

90 ✓ E 49736

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4305 St. Thomas St. 26-41 Ward)

2-FULL NAME Eva V. Burton

(a) RESIDENCE NO. 4305 ST. Thomas St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. E. Burton

6 DATE OF BIRTH (month, day, and year) Oct 14/1891

7 AGE	Years	Months	Days 17	IF LESS than 1 day ..... hrs. or ..... min.
	37	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Artimus R. Zepp

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Woodbine, Md.

12 MAIDEN NAME OF MOTHER Sarah E. Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Woodstock, Md.

14 Informant Nellie Weilbrenner (sister)
(Address) Hazelwood Ave nr Belair Rd

OCT 3 - 1929

H. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr. E. H. Tonnell

(Signed) [signature] M. D.

10/2/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 4 1929
20 UNDERTAKER	ADDRESS
Frederick Lassahn Sons	Fullerton

Spec.—1-12-23—M&T—500 Bks.

Quarino

HEALTH DEPARTMENT—CITY OF BALTIMORE

49737

CERTIFICATE OF DEATH.

46 E 49737

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hosp. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rob Anario

(a) RESIDENCE No. 133 E Cross St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Lawrence Anario

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At. Home.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Jos. Gentile.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Laurence Anario.

(Address) 133 E Cross St.

15 Filed 3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-2 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-19, 1929, to 10-2, 1929, that I last saw her alive on 10-2, 1929 and that death occurred, on the date stated above, at 5 10 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-23-29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL: Oct. 5 1929

20 UNDERTAKER: F. G. Pearce & Son.

ADDRESS: 703 Hom

Cor.—10-10-29—A Co.—100 Bks.

Ruth Grape

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49738

CERTIFICATE OF DEATH

177 ✓ E 49738

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary St. 16-44 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth Grape

(a) RESIDENCE NO. 4209 Seidel Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James B Grape

6 DATE OF BIRTH (month, day, and year) March 23/1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28	6	23	8

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of Industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Gustav Leibman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Bessie Luhn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant James B. Grape
(Address) 4209 Seidel Ave

15 Filed 10-3-1929 19 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia-Terminal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bichloride Mercury Poisoning-Probably Accidental

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes at Church Home

What test confirmed diagnosis?

(Signed) J. S. Collins M. D.

10-1-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem — DATE OF BURIAL Oct 3 1929

20 UNDERTAKER John Ullrich — ADDRESS 2008 Orleans

Nov 123

Spec.—8-16-29—L. F. S.—100 Bks.

E 49739 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 74 of E 49739

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 642 S. Macon ST. 26-36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josiah Buhrman

(a) RESIDENCE NO. 642. S. Macon ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Whia

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Buhrman

6 DATE OF BIRTH (month, day, and year) July 7. 1847

7 AGE: Years 82 | Months 2 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Rail road

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Henry H Buhrman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Charlotte Foote

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Caroline Buhrman

(Address) 642 S Macon

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

1929 per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1929, to Oct 1st, 1929

that I last saw him alive on Oct 1st 1929

and that death occurred, on the date stated above, at 10:50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Adam Fod, M. D.

, 19 (Address) 4700 Roslyn Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Highfield Md

DATE OF BURIAL: Oct 4 1929

20 UNDERTAKER: John Ulrich

ADDRESS: 700 Orleans

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49740

CERTIFICATE OF DEATH

90 E 49740

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 S. Chester St. ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Louise Garrett

(a) RESIDENCE NO. 21 S. Chester St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

a If married, widowed, or divorced WIFE of (or) HUSBAND of: John F. Garrett

DATE OF BIRTH (month, day, and year): Aug 7 1854

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75		24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): City

10 NAME OF FATHER: John Black

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Jane Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

Informant: Mary F. Garrett

(Address) 21 S. Chester St.

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 1, 29

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Oct. 1, 1929, that I last saw h[illegible] alive on Sept. 30, 1929 and that death occurred, on the date stated above, at 2.50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatism

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Lewis Heller, M. D.

10.7.1929 (Address) 193 Gough St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Oct 4, 1929

UNDERTAKER: John A. Moran — ADDRESS: 3000 E. Baltimore

Spec.—1-12-23—M&T—500 Blks.

E 49741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49741

1-PLACE OF DEATH
CITY OF BALTIMORE, (No.) 238 Colvin St. (Ward) 234

2-FULL NAME William Blaylock

(a) RESIDENCE No. 238 Colvin St. Ward 234

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.) N. C.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 1909.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	1	16.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Piping
(c) Name of employer Bethlehem Steel

9 BIRTHPLACE (city or town) Johnston Co.
(State or country) N. Carolina

PARENTS

10 NAME OF FATHER Wm. Blaylock

11 BIRTHPLACE OF FATHER (city or town) Wake Co
(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Roxie Lea

13 BIRTHPLACE OF MOTHER (city or town) Wake Co
(State or country) N. Carolina

14 Informant Cousins
(Address) 238 Colvin St

15 Filed T 3- 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/1/ 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-23 1929 to 10-1- 1929
that I last saw him alive on 10-1- 1929
and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchitis
(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J H Walton M. D.

, 19 (Address) 4438 St Georges

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clayton, N C

DATE OF BURIAL Oct 3 19

UNDERTAKER Lottie Gross

ADDRESS 1405 Mc Eldrey

Spec.—1-12-23—M&T—500 Blks.

49742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 E 49742

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 907 N. Carolina ST. 7-13 WARD)

2-FULL NAME Jacob Henry

(a) RESIDENCE NO. 907 N. Carolina ST., WARD Ala.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 12 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Henry

6 DATE OF BIRTH (month, day, and year) Sept 10 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64	~~1865~~	~~Sept~~	~~10~~ 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Ala

PARENTS

10 NAME OF FATHER Stephen Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Ala

12 MAIDEN NAME OF MOTHER Harriet Tomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Emma Henry (Address) 907 N. Carolina

15 Filed 3 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1929. to Sept 30, 1929.

that I last saw him alive on Sept 30, 1929.

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bilateral)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. 2 mos. 4 ds.

18 Where was disease contracted if not at place of death? At his home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood & Sputum.

(Signed) J.M. Miller, M. D.

(Address) 1613 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvery Cem	Oct 4 1929

20 UNDERTAKER Lottie Gross ADDRESS 1405 Mc Elderry

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49743

CERTIFICATE OF DEATH.

111-002

E 49743

1-PLACE OF DEATH Woman's Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 25-17 ..... WARD)

2-FULL NAME Sarah Ann Chase

(a) RESIDENCE NO. Curtis Bay % Quarantine ST., Hosp. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Thomas C. Chase

6 DATE OF BIRTH (month, day, and year) Apr 14 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Curtis Bay, Md.

PARENTS

10 NAME OF FATHER Elias Stallings

11 BIRTHPLACE OF FATHER (city or town) Broadneck (State or country) Anne Arundel Co. Md.

12 MAIDEN NAME OF MOTHER Rachel R. Solley

13 BIRTHPLACE OF MOTHER (city or town) Solley, (State or country) Anne Arundel Co. Md.

14 Informant Thomas C. Chase (Address) Curtis Bay % Quarantine Hosp.

15 Filed OCT 3 - 1929 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929 to Oct. 3, 1929.

that I last saw her alive on Oct. 3, 1929.

and that death occurred, on the date stated above, at 1:10 A. m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

(duration) ✓ yrs. ✓ mos 3 ds.

CONTRIBUTORY (Secondary) Gen. Peritonitis (duration) ✓ yrs ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct. 2, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Earle P. Clemson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Solley's Home Cemetery	Oct 6 1929
20 UNDERTAKER	ADDRESS
John F. DeHenry	715 Light St

Cor.—12-9-25—A Co—200 Bks.

E 49744

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 49744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1233 E. Monument St. 5-8 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward R. Brauner

(a) RESIDENCE NO. 1233 E. Monument St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence Brauner

6 DATE OF BIRTH (month, day, and year): Aug. 17 1880

7 AGE: Years 49 Months 1 Days 14 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter Oil Co

(b) General nature of Industry, business, or establishment in which employed (or employer): Gas & Electric Co.

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Joseph Brauner

11 BIRTHPLACE OF FATHER (city or town): _____

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Clark

13 BIRTHPLACE OF MOTHER (city or town): _____

(State or country): Md.

14 Informant: Florence Brauner

(Address) 1233 E. Monument St.

15 Filed _____ 19____ HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Myocarditis

(Duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. S. McCullough M. D.

(Coroner)

10/3/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary and

Date of Burial: Oct 4 1929

20 UNDERTAKER: Mrs. R. C. Elliott

ADDRESS: Woodlawn

Cor.—12-9-25—A Co.—200 Bks.

E 49745

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49745

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1750 Mulliken St., 6-9 Ward)

2-FULL NAME Sally Workman

(a) RESIDENCE NO. 1750 Mulliken St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Workman.

6 DATE OF BIRTH (month, day, and year): Aug 22 1886

7 AGE — Years: 43 — Months: 1 — Days: 3 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Chester

(State or country): S. C.

PARENTS

10 NAME OF FATHER: John Ryson

11 BIRTHPLACE OF FATHER (city or town):

(State or country): S. C.

12 MAIDEN NAME OF MOTHER: Anna Conrad

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): S. C.

14 Informant: John Workman

(Address): 1750 Mulliken St.

15 Filed ..... 19 .....

C. HARRISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sep 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Collins M. D.

(Coroner)

10-3-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Hill S. C. Date of Burial: Oct 3 1929

20 UNDERTAKER: Mrs. R. L. Elliott ADDRESS: 1325 Eutaw

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49746
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

84 ✓ E 49746
REGISTERED NO.

City of BALTIMORE: (No. 4137 Roland Ave. St., 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. McCourt

(a) RESIDENCE NO. 4137 Roland Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Mary A. McCourt

6 DATE OF BIRTH (month, day, and year) Sept. 1st. 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Police

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Police Dept.

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

10 NAME OF FATHER James McCourt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Grogan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Mrs. Mary A. McCourt

(Address) 4137 Roland Ave.

15 Filed 19 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1929 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 29 to Oct 1, 19 29

that I last saw h... alive on Oct 1, 19 29

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Pressure

(duration) ...yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Attendant circumstances

(Signed) C. Tuttle Jr. M.D.

10/2/29 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Cathedral Cemetery 10/4 1929

20 UNDERTAKER — ADDRESS

Chas. R. Fauce & Son 1180 N. Royal Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓

E 49747

CERTIFICATE OF DEATH.

E 49747
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1423 N. Central Ave St. 9-18 Ward)

2-FULL NAME Nicholas L. Gross

(a) RESIDENCE NO. 1423 N. Central Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Florence E. Gross

6 DATE OF BIRTH, (month, day, and year) July 11 1855

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
74	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Cigars

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Nicholas Gross

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Landecker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Florence E. Gross
(Address) 1423 N. Central Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar
3-1929 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 30th 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 28 1929, to Sept 31 1929, that I last saw h[illegible] alive on Sept 31 1929, and that death occurred, on the date stated above, at 5.27 P. m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency - Hemiplegia - Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observed signs

(Signed) L. M. C. Parker, M. D.

10/1, 19 29 (Address) 1114 Hartford Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — Date of Burial 10/3 1929

20 UNDERTAKER: Chas. P. Graves & Son — ADDRESS 118 W. Mt. Royal Ave

Spec.—12-9-25—A Co.—200 Bks.

E 49748

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 49748

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5406 Gerland Ave. St. 26-47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M. MacCubbin

(a) RESIDENCE NO. 5406 Gerland Ave. New Rd. 1/2 E. of Belair Rd. In City St. Ward (N E Police)

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): September 11th. 1911

7 AGE: Years 18 | Months — | Days 20 | IF LESS than 1 day ..... hrs. or ..... min. | 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

10 NAME OF FATHER Robert MacCubbin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Katherine Wiederspahn.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant Robert MacCubbin

(Address) 5406 Gerland Ave.

Filed Oct 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 1st. 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to Oct. 1, 1929, that I last saw h.e alive on Oct 1, 1929, and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) ? yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical-X-Ray

(Signed) Samuel B Wolfe, M. D.

10/2, 1929 (Address) 1331 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery. Date of Burial: Oct. 5th./29.

20 UNDERTAKER: Chas. F. Krauthoff ADDRESS 1180 N. Royal Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49749

CERTIFICATE OF DEATH.

101 1001 ✓

E 49749

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3823. Pleasant Place (Ward) 13-52

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie E. Curtis

(a) RESIDENCE. No. 3823. Pleasant Place. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada H. Curtis

6 DATE OF BIRTH (month, day, and year) March 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34.	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Weaver

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton mill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Warren. Md.

PARENTS

10 NAME OF FATHER Wm Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Ada. H. Curtis (Address) 3823 Pleasant Place

Filed OCT 3 - 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1st 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 28th, 1929, to Oct 1st 1929, that I last saw h[illegible] alive on Oct 1st 1929, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Tbc Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Tbc Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) B. A. Fillius, M. D.

10/3, 1929 (Address) 3614 Fair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Poplar Balto Co Md. DATE OF BURIAL Oct 4/1929

UNDERTAKER Walter Davis ADDRESS 3307 Pine St

Cor.—10-10-29—A Co.—0 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49750

CERTIFICATE OF DEATH

129 ✓

E 49750

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1031 Druid Hill St. 11-24 Ward)

2-FULL NAME Nicholas Cook

(a) RESIDENCE NO. 1031 Druid Hill St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1869 Feb 2-

7 AGE — Years: 60 — Months: 7 — Days: 26 — IF LESS than 1 day..... hrs. or..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country) "

PARENTS

10 NAME OF FATHER: Jo Cook

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):
(State or country)

14 Informant: Sarah Ann Yancey
(Address) 1031 Druid Hill

15 Filed 3-1929 HARRISON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Sept 28th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Sept 28th 1929 Albert Leech, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 10/3/29

20 UNDERTAKER: Daniel D Kemerly — ADDRESS: 578 N Bridle

Cor.—10-10-29—A Co.—100 Bks.

E 49751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 v

E 49751
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 19-28 Ward)

2-FULL NAME Charles W. ~~William~~ Lewis

(a) RESIDENCE NO. 1418 W. Lombard St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ada K. Lewis

6 DATE OF BIRTH (month, day, and year) Nov. 1 - 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	45	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer) Bowling alley
(c) Name of employer

9 BIRTHPLACE (city or town) ...
(State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Thomas Lewis

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Md

12 MAIDEN NAME OF MOTHER Isabella Taylor

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Md

14 Informant Mrs. Ada K. Lewis
(Address) 1418 W. Lombard St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquiry find that said deceased came to his death
(Inquest, autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...
(Signed) Eugene Zeller, M. D.
10/3 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct 5 1929
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

Emma Lynn.

E 49752

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 V E 49752

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 416 N Appleton ST., 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Lynn

(a) RESIDENCE NO. 416 N Appleton ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Zeb Lynn

DATE OF BIRTH (month, day, and year) Oct 5, 1887

AGE 41 42	Years	Months 11	Days 26	If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Pineville N. C.

10 NAME OF FATHER Thomas Means

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Katie Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

Informant Jesse Williams

(Address) 415 N. Appleton St

Filed ....., 19.. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Oct 1, 1929, that I last saw her alive on Sept 30, 1929, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Aortic Aneurysm (Ruptured)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) H. K. Cooley, M. D.

, 19 (Address) 1532 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Oct 3 1929

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

Holeman

E 49753

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49753

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1436 Aisquith ST. 9-18 (WARD)

2-FULL NAME Ellen Holman

(a) RESIDENCE No. 1436 Aisquith ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of Henry Holman

6 DATE OF BIRTH (month, day, and year) May 15th, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs. Lola Holman

(Address) 1436 Aisquith St.

15 Filed ..... 19..... C. HAMILTON JONES, M. D. Registrar

3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1929 to Oct 1, 1929.

that I last saw h~~e~~r alive on Oct. 1, 1929

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Morley Stoag M. D.

10/2, 1929 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dove Cathedral Cemetery	10/4 1929
20 UNDERTAKER	ADDRESS
E. J. Fanning & Son	1386 Lafayette Ave

rec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002 E 49754

E 49754

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Magdelna Bach

(a) RESIDENCE NO. 120 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Bach

DATE OF BIRTH (month, day, and year) 26 Juin 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A. Stone

BIRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER John Ripple

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Francis Spotson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant Little Sisters of the Poor

(Address) 120 Valley St

Filed 3 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2nd 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 2, 1929, that I last saw h[illegible] alive on Oct 1, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Hendelson M. D.

Oct 2nd 1929 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Joseph, Fullerton Md

DATE OF BURIAL 10/5 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 St Paul St

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49755

E 49755

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 452 Fawcett St. St. 12 Ward 12-51)

2-FULL NAME Fannie D Plowman

(a) RESIDENCE NO. 452 Fawcett St St. 12 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Plowman

6b DATE OF BIRTH (month, day, and year): Aug 13, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Pa

PARENTS

10 NAME OF FATHER: Jos Green

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Linda Church

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Charlotte Brewer

(Address): 1821 N Milton Ave

15 Filed 10-3-1929 16 H. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis or Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jos L Morrison M. D.

(Coroner)

10/2, 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys, Hampden — Date of Burial 10/4 1929

20 UNDERTAKER: W. Cook — ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49756

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital Ward) 34-34

2-FULL NAME Alice B. Rodey.

(a) RESIDENCE NO. 1526 William St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 0 mos. 15 ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

1929 E 49756

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed or divorced~~ (or) WIFE of Nelson M. Rodey.

6 DATE OF BIRTH (month, day, and year) September 16, 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	28	0	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William A. Jacobs.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Alice Burke.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Frederick, Md.

14 Informant Nelson M. Rodey. (husband)
(Address) 1526 William St.

15 Filed ... 19... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Sepsis due to an Abortion.
Criminal?

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute dilatation of the Heart

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted? If not at place of death? 1526 William St. 9/6/29

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry

(Signed) Otto M. Lennard, M. D.

10/3, 1929 (Address) 1007 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Oct 4 1929

20 UNDERTAKER E. Schluraun & Son ADDRESS 1039 Lemmon St

OCT 3 - 1929

Cor.—10-10-29—A Co.—100 Bks.

E 49757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

5/ E 49757

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1917 Sherwood Ave St., 4-16 (Ward)

2-FULL NAME Wm. H. Cromwell

(a) RESIDENCE NO. 1917 Sherwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary j. nee rice

6 DATE OF BIRTH (month, day, and year) July 11/1868

7 AGE	Years	Months	Days 20	IF LESS than 1 day ..... hrs. or ..... min.
	61	2	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 631
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Camden, N.J.

PARENTS

10 NAME OF FATHER Albert Cromwell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.J.

12 MAIDEN NAME OF MOTHER Sarah -------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.J.

14 Informant Wife
(Address) 1917 Sherwood Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

5 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Rheumatic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/3/1929 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	10/5/29 19
20 UNDERTAKER	ADDRESS
Geo J. Ruth	1035 Hanford Ave

Cor.—10-10-29—A Co.—100 Bks.

E 49758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 49758

1-PLACE OF DEATH

City of Baltimore: (No. 2234 W. Monroe St., 15-59 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Stansburg

(a) RESIDENCE No. 2234 W. Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary E. Stansbury

6 DATE OF BIRTH (month, day, and year) Mar 23-1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	6	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) Stafford Co
(State or country) Md

PARENTS

10 NAME OF FATHER Elizah Stansbury

11 BIRTHPLACE OF FATHER (city or town) Stafford Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Miles.

13 BIRTHPLACE OF MOTHER (city or town) Stafford Co
(State or country) Md.

14 Informant John E. Stansbury
(Address) 2234 W Monroe St

15 Filed ....., 19.. C. HAMPSON JONES, M. D.
OCT 3 - 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 3rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Harlan Brooks, M. D.

Oct 3rd 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethel Stafford Co, Md	Oct 5 1929
20 UNDERTAKER	ADDRESS
Wm C Brooks & Son	Sparks, Md

Spec.—1-10-21—M&T—1500 Bks.

E 49759 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 E 49759

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3515 E Balto ST. 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Sherwood Heck

(a) RESIDENCE NO. 3515 E Balto ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Heck

6 DATE OF BIRTH (month, day, and year) Nov. 24th 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	37	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md,

PARENTS

10 NAME OF FATHER Gustaf Heck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ida Heck
(Address) 3515 E. Balto. St.

15 1929 C. HAMPSON JONES, M. D.
Dat ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1929, to Oct 1, 1929, that I last saw h[illegible] alive on Oct. 1, 1929, and that death occurred, on the date stated above, at 10 05 A. m.

The CAUSE OF DEATH* was as follows:

Chr tonsillitis; acute nephritis; acute myocarditis.
Adhesions Rt. hand (7 days)

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. 3 mos ..... ds.

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Sept. 28, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clin. data

(Signed) J. Perkhellinger M. D.

..... 19 (Address) 3034 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery — DATE OF BURIAL Oct, 4 1929

20 UNDERTAKER Frank V. Pipitone — ADDRESS [illegible], Balto St

Spec.—1-12-23—M&T—500 Blks.

E 49760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1601 E 19760

1-PLACE OF DEATH Provident Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 14-20 WARD)

2-FULL NAME Infant Roye

(a) RESIDENCE NO. Provident Hospital ST., 1502 McCulloh St WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): —

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-30-29

7 AGE — Years — Months — Days — If LESS than 1 day 10 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leon S. Roye

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Ina Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address)

15 Filed 3-1929 C. HAMPSON JONES, M Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-30 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-30, 1929, to 9-31, 1929 that I last saw h— alive on 9-30, 1929 and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Cul. Atelectasis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ... 19

20 UNDERTAKER ... ADDRESS

Spgc.—2-29-28—L. F. S.—500 Blks.

E 49761

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

E 49761

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 13-59

CITY OF BALTIMORE: (No. 33rd & Calvert St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr Joseph A. Edmondson

(a) RESIDENCE NO. 2306 Mt Royal Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 0 mos. 18 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 12, 1865

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	0	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Mr. W. Edmondson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret L. Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Record

(Address)

Filed ....., 19 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3/29

17 I HEREBY CERTIFY, That I attended deceased from 9/30/29, 19..., to 10/3/29, 19..., that I last saw h... alive on 10/2/29, 19..., and that death occurred, on the date stated above, at 4.50 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis, Arteriosclerosis

(duration) 16 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis W. Gluck, M. D.

Oct 3rd, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	10/5 1929
20 UNDERTAKER Henry W. Mears & Son	ADDRESS 500 W. Calvert

Spec.–7-17-26—A Co.—200 Bks.

Barbara Kaiser

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49762

CERTIFICATE OF DEATH

41 E 49762

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1608 Elmtree (Curtis Bay) St. 93-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Kaiser.

(a) RESIDENCE NO. 1608 Elmtree St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 13 ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Kaiser.

6 DATE OF BIRTH (month, day, and year) April 19, 1869.

7 AGE: Years 60, Months 5, Days 13. IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Dont know.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dont know.

14 Informant William A. Kaiser, (Son).

(Address) Glenburnie.

15 Filed ..... 19 ..... Registrar

10-3-1929 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2nd 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1929, to Oct. 2, 1929, that I last saw h.. alive on Oct 2, 1929, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wm. T. Seabury, M. D.

Oct 3. 1929 (Address) 636 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial Oct 5 1929

20 UNDERTAKER: A. Howard Evans ADDRESS 38 E Fort Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49763

CERTIFICATE OF DEATH

90 ✓E 49763

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2206 Whittier ave ST. 13-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph [redacted] Felser

(a) RESIDENCE NO. 2206 Whittier ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE Rachael Felsher

DATE OF BIRTH (month, day, and year) 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe merchant

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER David Felsher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Winton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Rachael Felsher

(Address) 2206 Whittier ave

Filed 4-1929 HAMPSON JONES, M. D. Registrar

By RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/3/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Oct 3, 1929, that I last saw him alive on Oct 3, 1929, and that death occurred, on the date stated above, at 445 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis - arterio-sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lank, M. D.

10-3, 1929 (Address) Temple Gardens

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Wash Road	10/4 19 29
20 UNDERTAKER [illegible]	ADDRESS [illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49764

CERTIFICATE OF DEATH

90 E 49764

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3415 Parkheights ave St., 15-58 Ward)

2-FULL NAME Lenah Kleiman

(a) RESIDENCE NO. 3415 Parkheights ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? 27 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Abraham Kleiman

6 DATE OF BIRTH (month, day, and year) December.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of indostry, bosineas, or cstablishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Ben Kleiman
(Address) 3415 Parkheights ave

15 Filed - 1929, 19 HAMPSON JONES, M. D. Registrar RKK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Abdominal Disease
M J Heard

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation preeede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/3. 1929 (Address) 362 Rosedale ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL - 19
Mount Carmel	
20 UNDERTAKER Jack Louis	ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 49765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

109-02 49765

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Baker ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Yoes

(a) RESIDENCE NO. 1505 Baker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) March 4 1909

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	6	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O+O

(b) General nature of industry, business, or establishment in which employed (or employer) Helper on Coal truck

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Robert Yoes

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C.

12 MAIDEN NAME OF MOTHER Nellie Satchel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

Informant Elona Lancaster (Foster)

(Address) 1505 Baker St

Filed 1929 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1929, to Oct 1, 1929, that I last saw h alive on Sept 30, 1929 and that death occurred, on the date stated above, at 5.45 A.M.

The CAUSE OF DEATH* was as follows:

Acute Endo Carditis & Pericarditis

(duration) according to History yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Septic Tonsilitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Upshur M. D.

Oct 1, 1929 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery DATE OF BURIAL Oct 4" 1929

20 UNDERTAKER John M Johnson ADDRESS 2325 Madison Av.

Spec.—1-10-21—M&T—1500 Bks.

E 49766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 49766

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. ST., 713 WARD)

2-FULL NAME John C. Mank.

(a) RESIDENCE NO. 947 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Mank

6 DATE OF BIRTH (month, day, and year) Jan 11/1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City P. Dept.

(c) Name of employer Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry Mank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Winnicke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matilda Mank (Address) 947 N Washington St

15 Filed OCT 1929, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2 1929

17

I HEREBY CERTIFY, That I attended deceased from 9/28, 1929, to 10-2, 1929, that I last saw h alive on 10-2, 1929, and that death occurred, on the date stated above, at 12:15 P.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Myocardial failure.

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings

(Signed) A. A. Fisher, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Oct 5 1929
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 49767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

76 E 49767

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5106 Arabia Av ST., 27-44 WARD)

2—FULL NAME Chas. H. Diehl

(a) RESIDENCE NO. 5106 Arabia Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Frieda Diehl

DATE OF BIRTH (month, day, and year) May 25 '71

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C & P. Tel Co.

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Henry Diehl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Rebecca R Siegmund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

Informant Frieda Diehl

(Address) 5106 Arabia av

Filed OCT 4 1929 LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Oct 1, 1929, that I last saw him alive on Oct 1, 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema + Hypostasis

Hypostasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paresis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

Oct 4, 1929 (Address) 4702 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem. DATE OF BURIAL Oct. 4 1929

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Blks.

Hellman.

E 49768

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49768

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 1600 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Hallman

(a) RESIDENCE NO. Fairview Ave near Eastern Ave ST. WARD Colgate.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male. ~~Female~~

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliz. Hallman

DATE OF BIRTH (month, day, and year): Sept. 13/1884

AGE: Years 45 | Months 0 | Days 20 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Herman Hallman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

Informant: Hospital Record.

(Address)

T4 - 1928 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/2/29

17 I HEREBY CERTIFY, That I attended deceased from 9/17, 1929, to 10/2, 1929, that I last saw h[illegible] alive on 10/2 1929 and that death occurred, on the date stated above, at 10[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer

(duration) Unknown

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 9/25/29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) L. M. Rumpler M. D.

10/3, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: Oct 5 1929

20 UNDERTAKER: Philip Sterig

ADDRESS 2016 Orleans St.

E 49769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

41

E 49769

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins St. 3-4 Ward)

2-FULL NAME Bernard Caplan

(a) RESIDENCE NO. 1637 E. Balto Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4-1924

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	4	9 11	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto at. Md

PARENTS

10 NAME OF FATHER Sam Caplan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER
Coal

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Sam Caplan
(Address) 1637 E. Balto Street

15 Filed 4-1925 H. HARRISON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Odema of Laryax-Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mercy Hospital

(Signed) [illegible], M. D.

10/4/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mortimer cole Cem — DATE OF BURIAL: 10/4 1929

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 E Balto

Spec.—8-16-29—L. F. S.—100 Bks.

E 49770 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 49770

CERTIFICATE OF DEATH 31

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 1135 N. Carey ST. 6-23 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pauline Ryan

(a) RESIDENCE NO. 1135 N. Carey St ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 11, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	6	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Huntingtown Md

10 NAME OF FATHER Thomas H Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Victoria Gantt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Victoria Tyler

(Address) Huntingtown, Md.

Filed 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1929, to Oct 2, 1929, that I last saw h e alive on Sept 30, 1929 and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical sign.

(Signed) Chas J Keller, M. D.

10/2, 1929 (Address) 22 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Huntingtown, Md.	Oct 4, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 322 Schroeder St

Spec.—8-16-29—L. F. S.—100 Bks.

E 49771 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 49771

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 Orchard ST. 11-24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Brown

(a) RESIDENCE NO. 439 Orchard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Frederick Md

10 NAME OF FATHER: John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Filmore Brown

(Address) 653 N Mulberry St

Filed 4-1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1929, to Oct 2, 1929 that I last saw h[illegible] alive on Oct 2, 1929 and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: Oct 4 1929

20 UNDERTAKER: Samuel Beasley — ADDRESS: 578 N Eutaw

...ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49772

CERTIFICATE OF DEATH

101-001

E 49772

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1316 N. Strieker ST. (WARD) 15-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Calvin Colonel Dugger

(a) RESIDENCE NO. 1316 N. Strieker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma R. Dugger

DATE OF BIRTH (month, day, and year) June 29 1901

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	8	4 3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Lancaster Co

BIRTHPLACE (city or town) (State or country) Lancaster Co Pa

10 NAME OF FATHER James E. Dugger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Alice Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant Emma R. Dugger

(Address) 1316 N. Strieker St

Filed OCT 4 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929, to Oct. 2, 1929.

that I last saw him alive on Oct. 2, 1929.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. N. Pigg, M. D.

1073. 1929 (Address) 1536 W. Lafayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon	Oct 6th 1929
20 UNDERTAKER Sam'l H. Cline & Sons	ADDRESS Undertakers

Cor.—10-10-29—A Co.—100 Bks.

E 49773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-201 E 49773

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Fayette & Pine St. 12-50 Ward)

2-FULL NAME Philip Guckes

(a) RESIDENCE NO. 2613 Barclay St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Carolina Guckes

6 DATE OF BIRTH (month, day, and year) Jan. 26-1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	79	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Knabe Piano Co. 014

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Dr. P. G. Dill
(Address) 3815 Wilkens Ave

15 Filed 4-1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 - 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Eugene Gilbert, M. D.

Oct. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 4 1929

20 UNDERTAKER E. W. Dill ADDRESS [illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49774

CERTIFICATE OF DEATH

E 49774

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital St., Ward)

2-FULL NAME Joseph Ellwood Zimmers

(a) RESIDENCE NO. 2542 W. Fayette St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4- 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or .... min.
	43	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Elias Zimmers

11 BIRTHPLACE OF FATHER ~~(city or town)~~
(State or country) Pa

12 MAIDEN NAME OF MOTHER Mary E. Kramer

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Mary E. Ogle (Sister)
(Address) 2542 W. Fayette St

15 Filed ....., 19.... Registrar

4 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feller M. D.

10/4 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 5 1929
20 UNDERTAKER Harry A Kennard & Son	ADDRESS Edgewood Ave

Shaposhnikoff.

vec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22 E 49775 — CERTIFICATE OF DEATH — 11 E 49775

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Celia Shapos (Shaposhnikoff)

(a) RESIDENCE NO. 1103 E Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

DATE OF BIRTH (month, day, and year) Dec 10 1871 (or abt thereof)

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	9	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist

(b) General nature of industry, business, or establishment in which employed (or employer) unknown 031

(c) Name of employer unknown

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Records.

(Address) JOHNS HOPKINS HOSPITAL

Filed OCT 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 3, 1929,

that I last saw h... alive on Oct 3, 1929

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix
peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Post operative pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-30-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.

Oct 3. 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Circle Cemetery	Oct 4 1929
20 UNDERTAKER S. Levinson Bro	ADDRESS 1127 E Balto St.

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

54 ✓

E 49776

E 49776

PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgia Thompson

(a) RESIDENCE NO. 336 Dover St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) Sept 6-1902

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27		24	

OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Domestic servant

(b) General nature of industry, business, or establishment in which employed (or employer) o/o

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

Informant Wilson Thompson

(Address) 336 Dover St

Filed 1929, 19 HARRY D. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 19 29 to Sept 30, 19 29, that I last saw h alive on Sept 29, 19 29 and that death occurred, on the date stated above, at 6 4 m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 1 mos. 7 da.

CONTRIBUTORY (Secondary) Inanition, syphilis

(duration) yrs. mos. 17 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) W. H. Varney, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or In Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Ct	Oct 4 1929
20 UNDERTAKER	ADDRESS
S. S. Broun & Son	1814 Mon[illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49777

1-PLACE OF DEATH

CERTIFICATE OF DEATH

185 ✓ E 49777

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. South Baltimore General Hospital 1120 St. Ward)

2-FULL NAME Catherine Mc Cormick.

(a) RESIDENCE NO. 8 W. Oliver St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, [illegible] (or) WIFE of Patrick Mc Cormick.

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68	-------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Hand.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Joseph Mc Cormick.(son)
(Address) 1303 Mt. Royal Ave.

15 Filed [illegible], 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of the brain, fracture of both bones of both forearms. Shock. Accidental fall down a stairway.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 8 W. Oliver St. 10/1/29

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Steinhardt M. D.

10/4 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 10/5 1929

20 UNDERTAKER John J Foley Son — ADDRESS 1318 Light

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49778

CERTIFICATE OF DEATH.

E 49778

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 1928 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Beavan

(a) RESIDENCE No. 132 S. Gilmor ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 10-2-29

8 AGE — Years: — Months: — Days: 2 — If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

10 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Raymond Beavan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wash. D.C.

12 MAIDEN NAME OF MOTHER Eleanor Balan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Elenor Beavan
(Address) 132 S. Gilmor St

15 Filed 4-1929 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-2-29, 19..., to 10-4, 19 29

that I last saw him alive on 10-4, 19 29

and that death occurred, on the date stated above, at 2 a m

The CAUSE OF DEATH* was as follows:

Congenital heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem

DATE OF BURIAL: Oct 4th 19

20 UNDERTAKER: A. Jones

ADDRESS: 111 S. Gilmor

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49779 ✓ 90 E 49779

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3707 Garrison ST. 15-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna E Gainor

(a) RESIDENCE. NO. 3707 Garrison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7½ yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles T Gainor

6 DATE OF BIRTH (month, day, and year) Feb 26, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER George W Pouder

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Rhynhart

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant L S Pouder (Address) 410 Rutland Ave

15 Filed 4-1929 C. HAMPSON JAMES, M. D. Registrar By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1929

17 I HEREBY CERTIFY, that I attended deceased from Sept 26, 1929, to Oct 3, 1929, that I last saw h[illegible] alive on Oct 3, 1929, and that death occurred, on the date stated above, at 12 55 P m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency, with myocardial decompensation and failure

(duration) ? yrs. ? mos. 7 ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs

(Signed) H Riley Cole, M. D.

(Address) 2202 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 6 1929
20 UNDERTAKER George L Smith	ADDRESS 1532 Pulaski

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49780

113 V E 49780

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 571 Baker St. 14-59 Ward)

2-FULL NAME Dorothy Diggs

(a) RESIDENCE NO 571 Baker St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmale	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
		1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Robt Berry

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Diggs

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Robt Berry
(Address) 425 Madison Ave

15 Filed OCT 4 - 1929, 19... CLAYTON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Ed. E. Faltenbaker, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Oct 4 1929

20 UNDERTAKER Thomas E. Kelson ADDRESS 1303 Eutaw

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Tonry ✓ E North Ave

E 49781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11 2 E 49781

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2208 N Calvert ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A Cromwell

(a) RESIDENCE NO. 2208 N Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed or divorced HUSBAND of (or) WIFE of: Emma M Cromwell

7 DATE OF BIRTH (month, day, and year): March 26, 1857

8 AGE — Years: 72 | Months: 6 | Days: 6 | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): O & V

(c) Name of employer: Schlesinger

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Joseph Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Margaret Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Mrs Irene M Stahmer

(Address) 2208 N Calvert St

Filed 10/5/29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 2. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Oct 2, 1929

that I last saw h in alive on Sept, 1929

and that death occurred, on the date stated above, at 5 15 P m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

CONTRIBUTORY (Secondary): Heart Failure (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald I. Tonry, M. D.

10/3, 1929 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral

DATE OF BURIAL: 10/5 1929

20 UNDERTAKER: T. Cook

ADDRESS: 1217 E Pond St

ed.—2-29-28—L. F. S.—500 Blks.

E 49782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49782

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 11-24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Fuller

(a) RESIDENCE NO. 927 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) April 24, 1859

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51	5	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) West Virginia

10 NAME OF FATHER Tyler Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Lottie Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

Informant Records of

(Address) Baltimore City Hospitals

Filed ... 19 C. HAMPSON JONES, M. D.

1929 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 16, 19 29, to Sept. 29, 19 29

that I last saw h im alive on Sept. 29, 19 29

and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

over 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma & Hypertension

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. C.C. Lab. X-ray

(Signed) Marvin M. McLean, M. D.

9-1, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
CITY OF MARYLAND	19

20 UNDERTAKER

ADDRESS

...ec.—2-29-28—L. F. S.—500 Blks.

E 49783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 49783

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 14 59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maria Sheridan

(a) RESIDENCE NO. 2215 Pennsylvania Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): HD

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

(Address)

Filed 1929, 19

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 1, 1929.

17 I HEREBY CERTIFY, That I attended deceased from September 21, 19 29 to October 1, 19 29

that I last saw h alive on September 30 19 29

and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy
Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. H. Vatter M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 10/7 19

20 UNDERTAKER: Commissioner Health.

ADDRESS 1929

...ec.—2-29-28—L. F. S.—500 Blks.

E 49784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49784

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Franklin Square Hospital WARD)

2—FULL NAME Florence Louise Roerentrop

(a) RESIDENCE NO. 1913 W. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 12, 1883

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	46 Yrs	1	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millinery

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Frederick W. Roerentrop

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura L. Reinhardt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Mr. Frederick Roerentrop
(Address) 1907 W. Fayette St.

Filed 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 19 29, to Oct 3rd, 19 29, that I last saw h... alive on Oct 2nd, 19 29, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) ... yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. O. Peterson, M. D.

Oct 4, 19 29 (Address) 400 N. Payson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 5 19 29

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St.

Spec.—8-24-14—M. & T.—2000 Blks.

E 49785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 E 49785

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4420 Kathland ct ST.: 28-6-5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Lucy Howard Taliaferro

(Residence in Baltimore: No. 4420 Kathland ct St.: 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH July (Month) 10 (Day) 1854 (Year)

7-AGE, 70 yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Charlestown W Va

PARENTS.

10-NAME OF FATHER. Dr Solomon Bates

11-BIRTHPLACE OF FATHER (State or Country). Newtown Va

12-MAIDEN NAME OF MOTHER Margaret Shirley

13-BIRTHPLACE OF MOTHER (State or Country), Jefferson W Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J C Bennett

(Address) 4420 Kathland

15-

Filed OCT 4 - 1929

C. HAMPSON JONES, M. D.
Registrar

Per 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 4 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ~~Oct~~ Sept 12 1929, to Oct 4 1929, that I saw h[illegible] alive on Oct 3 1929, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

(Signed) Howard W. Warner M. D.

Oct 4, 1929. (Address) 2604 Garrison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Parsons W Va

DATE OF BURIAL. Oct 5. 1929.

20-UNDERTAKER [illegible]

ADDRESS Northern

...ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49786

CERTIFICATE OF DEATH

129 E 49786

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1118 Scott ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilhelmina Pabst.

(a) RESIDENCE NO. 1118 Scott ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Theo. Pabst.

DATE OF BIRTH (month, day, and year) Sept 25. 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73.	0	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Fred. Vahle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Marie Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant Frederick W. Pabst

(Address) 1015 Biscoe St.

Filed 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 /29

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Oct 4, 1929, that I last saw her alive on Oct 3, 1929 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and Chronic Nephritis

(duration) Chronic mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine Albs +++ Casts +

(Signed) Dan Francken, M. D.

10/4, 1929 (Address) 122 W Lex

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Oct 7th 1929
20 UNDERTAKER	ADDRESS
Mr. & Mrs. John W. Teufel & Son	86 W. Pigeon St.

Cor.—12-9-25—A Co.—200 Bks.

E 49787

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hotel Belvedere St., 11-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Howard Lloyd

(a) RESIDENCE NO. Hotel Belvedere St. Wye House Talbot Co Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Colrd.	Marrd

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1st 1859

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	70	2m	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Talbot Co

(State or country) Md

PARENTS

10 NAME OF FATHER Col Ed. Lloyd

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Howard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Talbot Md

14 Informant Mrs Jos Swiggett

(Address) Easton Md

15 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Carcinoma Pedoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer

(duration) 1 yrs. mos. ds.

Oct 4 (Signed) W. F. Kemp M. D.

, 19 (Coroner) (Address) Easton Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Talbot Co Md. Date of Burial Oct 5 1929

20 UNDERTAKER Geo. F. Jenkins & Co ADDRESS Easton Md

Cor.—10-10-29—A Co.—100 Bks.

E 49788

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 49788

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md. Gen. Hosp St., 19-26 Ward)

2-FULL NAME Willard F. Price

(a) RESIDENCE NO. 4 N Carey St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ely-Price

6 DATE OF BIRTH (month, day, and year) Apr 29-1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer) Wood
(c) Name of employer Carey

9 BIRTHPLACE (city or town) Fraser Md
(State or country)

PARENTS

10 NAME OF FATHER Willard F. Price

11 BIRTHPLACE OF FATHER (city or town) Fraser Md
(State or country)

12 MAIDEN NAME OF MOTHER Ely Woodward

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Easton Md

14 Informant Mrs. Willard F. Price
(Address) 4 N. Carey St.

15 Filed 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-2 192 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull —
Knocked down & assaulted by taxi cab — at Eutaw nr Preston

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eutaw nr Preston

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Coroner

(Signed) G. J. Fran M. D.

10/4 1929 (Address) 2739 N. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md. — DATE OF BURIAL Oct. 5 1929.

20 UNDERTAKER Charles J. Schwab — ADDRESS 525 N. Monroe St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49789

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1604 Bolton St. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick W. Patten

(a) RESIDENCE NO. 1604 Bolton St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Armstrong

DATE OF BIRTH (month, day, and year) Feb. ,1862

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	8		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 409

(b) General nature of industry, business, or establishment in which employed (or employer) C & P Telephone Co

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maine

10 NAME OF FATHER James Patten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Isabel Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

Informant Mrs. Jane A. Patten

(Address) 1604 Bolton St.

FILED 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1928. to Oct 3 1929.

that I last saw him alive on Oct 3 1929 4 P.M.

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation.
Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Ishbon M. D.

10.4. 1929 (Address) 711 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ridgewood, N. J.	Oct. 5, 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1900 Eutaw Pl.

W. B. Mitchell

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49790

CERTIFICATE OF DEATH.

74-001 V

E 19790

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE, (No. 4010 Kinsoak St. 27-15 Ward)

2-FULL NAME John H. Rollman Rotter Sr

(a) RESIDENCE NO. 4010 Kinsoak Road St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Rotter

6 DATE OF BIRTH (month, day, and year) Sept, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	72	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stock Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 645
(c) Name of employer: Self

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER: John Rotter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER: Christ Conrod

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant: John H. Rollman Jr
(Address) 4010 Kinsoak Road

15 [illegible] 19 [illegible]

1929

[illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

(Signed) Dan'l Morrissey M. D.
(Coroner)

10/4, 1929 (Address) 3672 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cemetery — Date of Burial: Oct 7th 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 49791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 49791

1—PLACE OF DEATH

REGISTERED NO. 16-23

CITY OF BALTIMORE (No. 906 N Fulton Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fred W. Briggeman

(a) RESIDENCE NO. 906 N Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug. 12. 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Fred W. Briggeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Nellie Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Nellie Briggeman

(Address) 906 N Fulton Ave

Filed 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4. 1929

17 I HEREBY CERTIFY, That I attended deceased from October 2- 1929, to October 4 1929;

that I last saw him alive on October 3- 1929.

and that death occurred, on the date stated above, at 6:30A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Otitis Media.

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

10-4- 1929 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Oct 5 1929
20 UNDERTAKER William Cook	ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49792

CERTIFICATE OF DEATH

74-001 E 49792

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Wyeth st ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Davis

(a) RESIDENCE NO. 521 Wyeth ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph F. Davis

DATE OF BIRTH (month, day, and year) Sept 16, 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	0	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in whirh employed (or employer) Home 037

(c) Name of employer Self

BIRTHPLACE (city or town) (State or rountry) Balto Md

10 NAME OF FATHER Conrad Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah V. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or rountry) Md

Informant Joseph F. Davis

(Address) 521 Wyeth st

Filed 19 C. HAMPSON JONES, M. D.

-1929 By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-29

17

I HEREBY CERTIFY, That I attended deceased from Oct 1 st, 1929, to Oct 4, 1929, that I last saw h alive on Oct 3, 1929, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Hemiplegia)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'W Carey M. D.

(Address) 700 N Payson st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 7th 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul st

spec.—2-29-28—L. F. S.—500 Blks.

E 49793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

21 E 49793

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Mason

(a) RESIDENCE NO. 1101 Burgundy st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1889

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

10 NAME OF FATHER Samuel Mason

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Alice Anderson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

Informant Hospital Records

(Address)

Filed 19 C. HAMPSON JONES, M. D. Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929, to Oct. 3, 1929.

that I last saw him alive on Oct. 3, 1929

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) M. D.

10-4-19 29 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 10/5 1929

20 UNDERTAKER W. M. Cook — ADDRESS 1217 St Paul St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49794

CERTIFICATE OF DEATH.

31 E 49794

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 356 S. Smallwood St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine E. Wich

(a) RESIDENCE NO 356 S. Smallwood St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. E. Wich

6 DATE OF BIRTH (month, day, and year): March 23-1897

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
32	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto., Md

(State or country)

PARENTS

10 NAME OF FATHER: John Erk

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Pauline M. Sibert

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany.

14 Informant: George E. Wich

(Address) 356 S. Smallwood St.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 2 1929

17

I HEREBY CERTIFY, That I attended deceased from May 1 1929 to Oct 2 1929,

that I last saw her alive on Oct 2 1929,

and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculosis Endaudetis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. C. Nelson, M. D.

(Address) 2507 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial Oct. 5 1929

20 UNDERTAKER: George L. Schwab ADDRESS 241 Fulton Ave

...ec. 2-29-28—L. F. S.—500 Blks.

E 49795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 49795

1—PLACE OF DEATH

REGISTERED NO.

...ITY OF BALTIMORE: (No. 612 N Madeira ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Whitfield

(a) RESIDENCE NO. 612 N. Madeira ST., WARD

(Usual place of abode)

...ngth of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

If married, widowed, or divorced
(or) WIFE of Lee Whitfield

...DATE OF BIRTH (month, day, and year) 1901

...GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28			

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

...IRTHPLACE (city or town) Md.
(State or country)

10 NAME OF FATHER Chas Stanley

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ella Pinder

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

Informant [redacted]

(Address) Lee Whitfield 612 N Madeira

Filed ... 19 ...

...HAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1929, to Oct 4, 1929, that I last saw h[illegible] alive on Oct 2, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis and Enlarged Liver. (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

Oct 4 1929 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. Balto. Md.

DATE OF BURIAL Oct 7 1929

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

...ec.—2-29-28—L. F. S.—500 Blks.

E 49796 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 49796

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 257 E Hamburg ST. 24th WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mabel I Frazier

(a) RESIDENCE NO. 257 E Hamburg ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) Jan 1 1917

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	10	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

BIRTHPLACE (city or town) (State or country) Cambridge Md

10 NAME OF FATHER John W Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Rossie E Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

Informant Mr John W Frazier

(Address) 257 E Hamburg St

Filed OCT 8 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 1 29, 19..., to Oct 4 29, 19..., that I last saw her alive on Oct 4 29, 19..., and that death occurred, on the date stated above, at 12 28 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

CONTRIBUTORY (Secondary) ... (duration) yrs. 3 mos. ... ds.

Rheumatism

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos B Kroll M. D.

Oct 4 1929 (Address) 1737 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Oct 5 1929

20 UNDERTAKER John F Denny ADDRESS 715 Lig Ut St

...ec.—2-29-28—L. F. S.—500 Blks.

E 49797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 49797

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1128 E Worth Ave ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara E Richardson

(a) RESIDENCE NO. 1128 E Worth Ave ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Richardson

DATE OF BIRTH (month, day, and year): 5-17-1875

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	4	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Adolph Semple

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Bertha Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

Informant: A Richardson

(Address): 1128 E Worth Ave

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-2-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 . 19 29 to 10-2 . 19 29 that I last saw her alive on 10-1 . 19 29 and that death occurred on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows: Nephritis; Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Ind. Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Fred Semple M.D.

10-4-29 (Address) 880 N Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Oct 5 1929

UNDERTAKER: Mary M Medefield

ADDRESS: 501 E 22nd St

...ec.—2-29-28—L. F. S.—500 Bks.

E 49798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 49798

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Dodson

(a) RESIDENCE NO. 1811 Madison ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

DATE OF BIRTH (month, day, and year) 9-18-29

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Md
(State or country)

10 NAME OF FATHER Hugh Dodson

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Young

13 BIRTHPLACE OF MOTHER (city or town) NY
(State or country)

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929, to Oct 4, 1929, that I last saw him alive on Oct 4, 1929 and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones M. D.

10/3, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	10/5/1929
20 UNDERTAKER	ADDRESS
Wm. Leo. H. Holland	1631 Druid Hill

pec.—2-29-28—L. F. S.—500 Bks.

E 49799 · HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 49799

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Metcalf - Jr -

(a) RESIDENCE NO. Mexia - Texas ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie

DATE OF BIRTH (month, day, and year) 4/29/75 -

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist - 0 5 5

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Ala -

10 NAME OF FATHER James F Metcalf

11 BIRTHPLACE OF FATHER (city or town) Ala - (State or country)

12 MAIDEN NAME OF MOTHER Hattie Snell

13 BIRTHPLACE OF MOTHER (city or town) Ala - (State or country)

Informant Records - JOHNS HOPKINS HOSPITAL (Address)

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct - 4 - 29

17

I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1929, to Oct 4, 1929, that I last saw him alive on Oct 4, 1929, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor, glioma, benign.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock, 2 hrs -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 9 X 29

Was there an autopsy? yes

What test confirmed diagnosis? operation, removal of tumor

(Signed) E H Campbell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mexia Texas	Oct 5th 1929
20 UNDERTAKER Jos Joerdens & Son	ADDRESS 2178 Penn

pec.—1-12-23—M&T—500 Blks.

E 49800 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

106 E 49800

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 Arlington Ave ST., 27-45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Hay

(a) RESIDENCE NO. 823 Arlington Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Baby

a If married, widowed, or divorced HUSBAND of or) WIFE of ✓

DATE OF BIRTH (month, day, and year) Feb 1929

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	8	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER William Hay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Viola Williams

(Address) 2506 Puget St

Filed ..... 1929 ..... 19 C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-3- 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, to Oct 3rd, 1929, that I last saw him alive on Oct 2nd, 1929, and that death occurred, on the date stated above, at 3:25 P. m.

The CAUSE OF DEATH* was as follows:

Catarrhal Pneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pul. Congestion

(duration) ..... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) H. H. Calyer, M. D.

, 19 (Address) 1263 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Oct 5, 1929

20 UNDERTAKER Mrs Kate R. Williams — ADDRESS 322 N Schroeder St

Dec.—2-29-28—L. F. S.—500 Bks.

E 49801

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 E 49801

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-27 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Matthews

(a) RESIDENCE NO. 627 N. Mount ST., WARD A-2
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, or ~~Divorced, (write the word)~~
Female	Colored	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of William Matthews

DATE OF BIRTH (month, day, and year) Sept 27, 1880

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49		6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Thomas (Unknown)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Estha Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 3/29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1929, to Oct. 3, 1929, that I last saw h[illegible] alive on October 3, 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

I. Respiratory tuberculosis

Incurable malignant tumor, right renal or retroperitoneal origin.

Uremia (duration) Unknown yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypernephroma

Postoperative shock (duration) 6 hours. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? yes Date of 10-3-29

Was there an autopsy? yes

What test confirmed diagnosis? Surgery + autopsy.

(Signed) Raymond K. Turner M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Oct 7, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 327 N Schroeder

...ec.—2-29-28—L. F. S.—500 Blks.

E 49802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49802

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3000 Clifton Ave St.) 5-61 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. Clement Heaton Warner

(a) RESIDENCE NO. 3000 Clifton Ave. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Warner

DATE OF BIRTH (month, day, and year) Oct. 29 1858

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	11	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist 55

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER John Edw. Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Wilkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Mrs. Virginia Warner

(Address) 3000 Clifton Ave.

Filed 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 2nd, 1929, to Oct. 3rd, 1929, that I last saw him alive on Oct. 3rd, 1929, and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac C. Dickson, M. D.

Oct. 4 1929 (Address) 3055 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Oct. 5 1929
20 UNDERTAKER Wm. Tickner Sons	ADDRESS North & Pa

Spec.—1-12-23—M&T—500 Blks.

E 49803 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49803

CERTIFICATE OF DEATH

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp. (ST.) 20-70 (WARD)

2-FULL NAME August H. Kuhlemann

(a) RESIDENCE NO. 2961 Frederick Av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced

HUSBAND of (or WIFE of): Mrs. Mary A. Kuhlemann

DATE OF BIRTH (month, day, and year): Dec. 13, 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	71			
	72 yrs.	9	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Washington D.C.

10 NAME OF FATHER: Charles Frederick Kuhlemann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hanover, Germany

12 MAIDEN NAME OF MOTHER: Lizetta Heggeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hanover Germany

Informant: Hospital record

(Address)

Filed 1929 19

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/4 29

17

I HEREBY CERTIFY, That I attended deceased from Sept 18 29 to Oct. 4 29

that I last saw him alive on Oct. 4 29

and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma of Prostate

Abnt one year (duration)

CONTRIBUTORY (Secondary): Celebral Embolism (duration) yrs mos 6 ds

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 9/24/29

Was there an autopsy? no

What test confirmed diagnosis? Biopsy

(Signed) J. H. Hagan M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Oct 7 19 29

UNDERTAKER: Wm J Groener

ADDRESS: Govans Md

Spec.—8-16-29—L. F. S.—100 Bks.

E 49804 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 90 E 49804

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 Druid Hill Ave ST. 17-24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marcelena Young

(a) RESIDENCE NO. 1340 Druid Hill Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) July 27 1876

AGE: Years 53 | Months 2 | Days 06 | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Alfred Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Coppuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Rowena E Young

(Address) 1100 Bentalou St

Oct 5 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to Oct 3, 1929, that I last saw h[er] alive on Oct 3, 1929, and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Cardio-renal Disease (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

Oct 4, 1929 (Signed) H S McCard M. D. (Address) 2008 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Oct 5 1929

20 UNDERTAKER Samuel Kennedy ADDRESS Mt Belle

Cor.—10-10-29—A Co.—100 Bks.

Michael A. Mahoney

E 49805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 49805

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 567 E. 38th St. 9-47 Ward)

2-FULL NAME Michael A. Mahoney

(a) RESIDENCE NO. 567 E. 38th St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Stella Mahoney

6 DATE OF BIRTH (month, day, and year) June 26/1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33	3	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 66
(b) General nature of industry, business, or establishment in which employed (or employer) Candy
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Toronto, Canada

PARENTS

10 NAME OF FATHER Michael A. Mahoney

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland?

14 Informant Mrs. Mary Franke
(Address) 567 E. 38th St

15 Filed ..... 19 29 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and frum the evidence ubtained hy said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cardiac Valvular Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation by friends

(Signed) J. H. Mairs, M. D.

10/4/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL Toronto, Canada DATE OF BURIAL 10/6/29

20 UNDERTAKER J. J. Doran ADDRESS 300 E. Balto.

...ec.—2-29-28—L. F. S.—500 Bks.

E 9727
E 49806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 84

E 49806

1—PLACE OF DEATH

REGISTERED NO.

...ITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Beulah Messersmith

(a) RESIDENCE NO. 163 N. Frederick ST. Ht WARD Millersville Md
(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Rec. E. E. Messersmith

...DATE OF BIRTH (month, day, and year) 6/2/90

...AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	4	7	

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

...IRTHPLACE (city or town) (State or country): Pa -

10 NAME OF FATHER Geo. Israel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga -

12 MAIDEN NAME OF MOTHER Sarah Kachsadz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa -

Informant: Records -

(Address) JOHNS HOPKINS HOSPITAL

Filed C. HAMPSON JONES, M. D. Registrar

1929 -

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct - 4 - 29

17 I HEREBY CERTIFY, That I attended deceased from Oct - 3, 1929, to Oct - 7, 1929.

that I last saw her alive on Oct 4, 1929

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor Surgery

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 4. X. 29

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) H. H. Cameron Jr., M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Conestoga Pa Millersville Evan Cem	10-8-29
20 UNDERTAKER J. W. Mayer	ADDRESS 4122 Walnut Balto

pec.—2-29-28—L. F. S.—500 Blks.

E 49807 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49807

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 4-7 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edgar Sewell

(a) RESIDENCE NO. Brown's Island ST., WARD
(Usual place of abode) Calvert Co., Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Joseph Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Pritchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Ernest Barrett

(Address) 420 Grindale St

Filed 10-5-1929, 19 RRN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Oct 5, 1929,

that I last saw him alive on Oct 5, 1929

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Heyko, M. D.

10/5, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Broomes Island Md Via auto	Oct 6 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

CHARLES JONES, M.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49808 HEALTH DEPARTMENT—CITY OF BALTIMORE V-09 E 49808

CERTIFICATE OF DEATH

161-0

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2804 Waldorf Ave St. 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Un named Infant Kell

(a) RESIDENCE NO. 2804 Waldorf Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) Oct 4th 1929

AGE: Years | Months | Days | If LESS than 1 day 12 hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER Clarence Kell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Mabel Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant Clarence Kell

(Address) 2804 Waldorf ave

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 5, 1929

that I last saw her alive on Oct 4, 1929

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Congenital weakness,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolonged labor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) C. D. Evans, M. D.

10-5, 1929 (Address) 4936 North Charles ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 10-5th 1929

20 UNDERTAKER: Henry W. Jenkins Sons Co — ADDRESS: Orchard & McCulloh

Spec.—2-29-28—L. F. S.—500 Bks.

2E 43303 — HEALTH DEPARTMENT—CITY OF BALTIMORE — X 84 ✓ E 49809

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert James

(a) RESIDENCE NO. Hampton Va ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice

DATE OF BIRTH (month, day, and year): 4-30-99

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	5	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 109

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: William A

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Annie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed ..... 19 .....

6 - 1929 — C. HAMPTON JONES, M. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct-5 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Oct 5, 1929, that I last saw him alive on Oct 5, 1929, and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Brain tumor, Cancer

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 21 Sept 29

Was there an autopsy? Yes

What test confirmed diagnosis? operation

(Signed) Edith Campbell Bancroft, M. D.

10/5, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hampton Va	Oct 6 1929
20 UNDERTAKER	**ADDRESS**
Henry W. Mearsdon	805 N. Calvert St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49810

CERTIFICATE OF DEATH.

× 51 E 49810

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St Agnes Hospital ST. 25-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irvin White

(a) RESIDENCE NO. St Francis Xavier School ST. WARD Cockeysville Md.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) February 1921

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) md

10 NAME OF FATHER John R White

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Agnes B. Kraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

Informant Mrs. Agnes White

(Address) Cockeysville Md

Filed 10 - 1929 H. HAWKINS JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-28, 1929, to 10-4, 1929, that I last saw him alive on 10-4-29, 1929, and that death occurred, on the date stated above, at 10.20 P m

The CAUSE OF DEATH* was as follows:

Rheumatic fever
- rheumatic pancarditis
followed by staphylococcus
septicemia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed George Brenner, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White's Family Cem

DATE OF BURIAL Oct. 7 1929

20 UNDERTAKER Easton Sons

ADDRESS Edicott City

ec.—2-29-28—L. F. S.—500 Bks.

28069

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49811

CERTIFICATE OF DEATH

58-001 ✓ E 49811

1—PLACE OF DEATH

REGISTERED NO.

ITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L. Snyder

(a) RESIDENCE NO. 119 Bland Ave ST., WARD Cumberland - Md
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Md —

10 NAME OF FATHER Ed - Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Mary Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

Filed 3-1929 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-5-29

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1929, to Oct - 5, 1929, that I last saw her alive on Oct - 5, 1929 and that death occurred, on the date stated above, at 8 05 a.m.

The CAUSE OF DEATH* was as follows:

Epidural Abscess

8 (duration) — yrs. 11 mos. — ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? Not done

What test confirmed diagnosis? Path. Exam.

(Signed) Alexander Hunter, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland Md	Oct 7 1929
20 UNDERTAKER	ADDRESS
Wilson & Schaffer	186 Baltimore St.

spec.—1-12-23—M&T—500 Bks.

Keene

E 49812

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49812

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 Etting ST. 1724 WARD)

2-FULL NAME Mrs. Nevis Keene

(a) RESIDENCE NO. 1133 Etting ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Maggie Keene

DATE OF BIRTH (month, day, and year) Oct 13 1892

AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
36	11	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Madison Dorchester Co., Md

10 NAME OF FATHER George Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Madison Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Madison Dorchester Co., Md

Informant Maggie Keene

(Address) 1133 Etting St

Filed 10-5-1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4/1929

17

I HEREBY CERTIFY, That I attended deceased from 8/25, 1929, to 10/4, 1929, that I last saw him alive on 10/4, 1929, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 2 ds

CONTRIBUTORY (Secondary), Pulmonary Tuberculosis (duration) yrs. 7 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & History

(Signed) John H. Toadvine, M. D.

, 19 (Address) 709 Hearst Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	Oct 6 1929
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Hamd Hill

Spec.—1-12-23—M&T—500 Blks.

E 49813 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 49813

CERTIFICATE OF DEATH. 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged men + women's Home ST. 23rd WARD)

2-FULL NAME George Dowson

(a) RESIDENCE No. 818 N. Carrollton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Cold	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) 1849

8 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	80			

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

11 NAME OF FATHER Unknown

12 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

13 MAIDEN NAME OF MOTHER Unknown

14 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

15 Informant Mrs Robinson (Address) 818 N. Carrollton Ave

Filed OCT 6 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1929, to Oct 4, 1929, that I last saw h[illegible] alive on Oct 4, 1929 and that death occurred, on the date stated above, at 12 N. m

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley M. D

10/6 1929 (Address) 1530 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Oct 6 1929

20 UNDERTAKER Geo. H. Frazier — ADDRESS 1027 Druid Hill

rec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49814

CERTIFICATE OF DEATH

129 ✓

E 49814

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 E Preston ST. 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John D Tilyard

(a) RESIDENCE NO. 4 E. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: M.

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~: Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Lelia Tilyard

DATE OF BIRTH (month, day, and year): Dec 17th 1856

AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	72	9	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Decorator

(b) General nature of industry, business, or establishment in which employed (or employer): 053

(c) Name of employer: Self

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Alfred Tilyard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Mrs Lelia Tilyard

(Address): 4 E Preston St

Filed ... 19... C. HARRISON JONES, M. D. Registrar

5-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 4, 1929

17

I HEREBY CERTIFY, That I attended deceased from ..... 19 17, to Oct. 4 ..... 19 29, that I last saw h/~~e~~ alive on Oct. 3rd, 1929 and that death occurred, on the date stated above, at 6 A. 40 m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension

Chronic Hypertension Nephritis

Chronic Myocardial Insufficiency

(duration) About 6 yrs. mos. — ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard M. D.

Oct. 1929 (Address) 4 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Oct 7 1929

20 UNDERTAKER: Kertland — ADDRESS: 1723 N Lafayette

Spec.—8-16-29—L. F. S.—100 Bks.

49815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 V

E 49815

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 George St. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Baughon

(a) RESIDENCE NO. 638 George ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 38 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 1862

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Paul Tolbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Louise Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Mamie Busby

(Address) 638 George St

Filed OCT 6 1929, 19 H. HANSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 25 1929, to Oct. 3, 1929, that I last saw her alive on Oct. 3, 1929, and that death occurred, on the date stated above, at 2.08 P. m.

The CAUSE OF DEATH* was as follows:

Hypostasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hawk E. Wagner M. D.

10/6, 29 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Oct 5 1929

20 UNDERTAKER: Paul L. Townsley

ADDRESS 578 N Bond

ec.—2-29-28—L. F. S.—500 Bks.

E 49816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 V

E 49816

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 3911- ~~Kenington~~ Kennison Av St. 28-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Maggio

(a) RESIDENCE NO. 3911-1 ~~Kennington~~ Kennison Av ST.

(Usual place of abode)

WARD

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Concetta Maggio

ATE OF BIRTH (month, day, and year) 4-10-1862

AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	67	5	23	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer) Opr. Retired

(c) Name of employer

IRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Vincent Maggio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Maggio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Charles Maggio

(Address) 3911 Kennington Av

Filed - WILLIAM H. JONES, M. D. Registrar

War

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929 to Oct. 3, 1929

that I last saw him alive on Oct. 2, 1929

and that death occurred, on the date stated above, at 1.50 A. m.

The CAUSE OF DEATH* was as follows

Broncho-Pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorhage.

(duration) yrs mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. L. Tumminello, M. D.

. 19 (Address) 306 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	10/5/29
20 UNDERTAKER George J Poth	ADDRESS 1735 Hoffman

ec.—2-29-28—L. F. S.—500 Blks.

E 49817 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 49817

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 4122 Park Heights Avenue WARD) 58

2—FULL NAME Theresa Rosso

(a) RESIDENCE NO. 4122 Park Heights Avenue ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Rosso

ATE OF BIRTH (month, day, and year) 10/14/1880

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48		11	19	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 27

(c) Name of employer

IRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Vincent De Stefano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Sarah De Stefano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Philip Rosso

(Address) 4122 Park Heights Avenue

Filed 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Oct 3, 1929

that I last saw h alive on Oct 3, 1929

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

CONTRIBUTORY (Secondary) Exhaustion (duration) 1 yrs 9 mos ds.

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan/1928

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Campbell M. D.

Oct 4, 1929 (Address) 1644 Harwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	10/6, 1929
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Harford Avenue

Spec.—2-29-28—L. F. S.—500 Bks.

E 49818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 49818

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 S. Longwood ST. 20-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Joseph Paul Pushworth

(a) RESIDENCE NO. 533 S. Longwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? 8 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Walter Mary Pushworth

DATE OF BIRTH (month, day, and year) 8-11-1853

AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	6	1	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 29

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bradford England

10 NAME OF FATHER George Pushworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Monica Pushworth

(Address) 533 S. Longwood

Filed ....., 19.... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4/29

17

I HEREBY CERTIFY, That I attended deceased from Oct 2, 1929, to Oct [illegible], 1929,

that I last saw him alive on Oct 4, 1929

and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Lobar Cardiac Dilatation

[illegible] weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) J. C. Eldren, M. D.

, 19 (Address) 14[illegible] E Bell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	10/7/29 19
20 UNDERTAKER George J. Ruth	ADDRESS 1235 Hanover

Spec.—1-10-21—M&T—1500 Blks.

E 49819 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49819

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md.

CITY OF BALTIMORE: (No. ..... ST., 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Larrabee

(a) RESIDENCE NO. ..... Machiasport, Maine ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Larrabee

6 DATE OF BIRTH (month, day, and year) Aug. 27, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Schr. Brina P.Pendleton

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER James P. Larrabee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Me

12 MAIDEN NAME OF MOTHER Josephine Robbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

15 Filed 6 - 1929 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1929

17 I HEREBY CERTIFY, That I attended deceased from September 30, 1929, to October 5, 1929, that I last saw him alive on October 5, 1929, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage, cerebral

(duration) yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) --

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto., Md.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory

(Signed) Ralph L Porter M. D.

10/5, 1929 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Searsport, Maine	Oct. 6, 1929

20 UNDERTAKER E. Leroy Stiffler, Inc. ADDRESS 125 E. North ave.

pec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E-PL 19820 EATH

31 E 49820

REGISTERED NO.

CITY OF BALTIMORE: (No. 1946 W Lanvale St. 16-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Otto F Franz

(a) RESIDENCE NO. 1946 W Lanvale St.
(Usual place of abode)

WARD

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Sept 24 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	0	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Conrad Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Anthony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Rudolph Franz

(Address) 1946 W Lanvale St

Filed 6 - 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 1929 to Oct 5 1929

that I last saw h alive on Oct 4 1929

and that death occurred, on the date stated above, at 5-15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. 5 mos. 28 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James D Cassidy M. D.

10/5 1929 (Address) 1729 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL 10/7/29

UNDERTAKER E Kirby Sutton ADDRESS Fayette

Spec.—1-12-23—M&T—500 Blks.

E 49821

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49821

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3025 Elliott ST. | 1 | WARD)

2-FULL NAME Anastacia Kowalewicz

(a) RESIDENCE No 3025 Elliott ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single.

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) 4/2/22

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	6 mo	3 dy	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Joseph Kowalewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Cusko

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant (Address) Joseph Kowalewicz 3025 Elliott St.

Filed ..., 19 C. HAMILTON JONES, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5 1927

17

I HEREBY CERTIFY, That I attended deceased from October 3, 1927, to October 5, 1927, that I last saw h[illegible] alive on October 5, 1927 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Carditis, mitral stenosis and Regurgitation

(duration) yrs. 2 mos 20 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. 2 mos. 20 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Only physical

(Signed) J. M. Miller, M. D.

10-6, 1927 (Address) 1613 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Cemetery	10/7 1927
20 UNDERTAKER	ADDRESS
Chas. B. Kuchlauskas	637 S. Haven

...—2-29-28—L. F. S.—500 Bks.

49822 HEALTH DEPARTMENT—CITY OF BALTIMORE 6 49822

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

ITY OF BALTIMORE: (No. Lombard & Green ST. 4-30 WARD)

REGISTERED NO. [redacted]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Plunkert

(a) RESIDENCE NO. Pleasant Hill, Md ST., WARD

(Usual place of abode)

ngth of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

ATE OF BIRTH (month, day, and year) April 4-1926

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	6	2	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) Carroll Co
(State or country) Maryland

0 NAME OF FATHER Edward Plunkert

1 BIRTHPLACE OF FATHER (city or town) Adams Co
(State or country) Penna

2 MAIDEN NAME OF MOTHER St. Clara Willet

3 BIRTHPLACE OF MOTHER (city or town) Carroll Co
(State or country) Maryland

Informant Edward Plunkert

(Address) Westminster Md R.F.D.

Filed 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Oct 6, 1929,

that I last saw him alive on Oct 6, 1929

and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

Para typhoid fever (B)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. B. Johnson, M. D.

Oct. 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Silver Run Cem	Oct 7 1929
20 UNDERTAKER	ADDRESS
John W. Little	Littlestown Pa

...ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

No. 49823

CERTIFICATE OF DEATH

1—PLACE OF DEATH. University Hospital (Lombard & Greene Sts) (Baltimore) REGISTERED NO. 100-0[illegible]

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Muriell Bell

(a) RESIDENCE NO. Alberton, Md. Relicta Ave ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) December 7, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Alberton (State or country) Balto. Co. Md.

10 NAME OF FATHER John F. Bell

11 BIRTHPLACE OF FATHER (city or town) Berryville (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha V. Reeder

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Maryland

Informant John F. Bell

(Address) Alberton Md.

Filed Oct 9 1929 C. HARRISON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929 to Oct 6, 1929 that I last saw h[illegible] alive on Oct. 6, 1929 and that death occurred, on the date stated above, at 5:05 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Senility, Rickets

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. B. Johnson, M. D.

Oct. 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Good Shepherd	Oct 8, 1929
20 UNDERTAKER	ADDRESS
Easton Sons	Ellicott City, Md.

...—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49824 — CERTIFICATE OF DEATH — 10-002 — E 49824

1—PLACE OF DEATH

REGISTERED NO.

ITY OF BALTIMORE: (No. 623 N. Madeira ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawson Bernard Craig

(a) RESIDENCE NO. 623 N. Madeira ST., WARD
(Usual place of abode)

ngth of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	S

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

ATE OF BIRTH (month, day, and year) Aug. 13, 1925

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	4	1	23	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Bernard Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Alverta Bowles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

Informant Mrs. Craig

(Address) 623 N. Madeira

Filed 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 29

17

I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929, to Oct. 6, 1929, that I last saw h. L alive on Oct. 6, 1929, and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Con)

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Pneumogastric Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) William L. Lazenby M. D.

. 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem	Oct 7 1929
20 UNDERTAKER	ADDRESS
Robert E. Williams	1515 McElderry St

Spec—12-23-21—E.B.R.S.—400 Eks.

E 49825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49825

1-PLACE OF DEATH

City of BALTIMORE: (No. 753 Dolphin St., 17-24 Ward) Registered No. 47

2-FULL NAME Clara E. Hall

(a) Residence No. 753 Dolphin St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph A. Hall

6-DATE OF BIRTH (month, day and year) ? 1880

7-AGE. 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Philadelphia Pa.

PARENTS.

10-NAME OF FATHER, Jackson Eddy

11-BIRTHPLACE OF FATHER (city or town) Philadelphia (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER, Julia Jackson

13-BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or Country), Pennsylvania

14- (Informant) Leon Hall (Address) 753 Dolphin St.

15- 7-1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 3- 29

17- I HEREBY CERTIFY, That I attended deceased from August 6 1923 to October 4 1924, that I last saw her alive on October 3rd 1924, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Mammary gland

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Burwell Fargo M. D.

, 19 (Address) 2937 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel — DATE OF BURIAL, 10/2/29

20-UNDERTAKER, Mrs. Leo H. Holland — ADDRESS 1631 Druid Hill Ave

...—2-29-28—L. F. S.—500 Bks.

E 49826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49826

REGISTERED NO.

1—PLACE OF DEATH

ITY OF BALTIMORE: (No. 1236 W. Gay St ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna M Henry

(a) RESIDENCE NO. 1236 W Gay St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

ngth of residence in city or town where death occurred 63 yrs. 9 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
(or) WIFE of Eugene A Henry

ATE OF BIRTH (month, day, and year) Feb 24 1865

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	63	9	11	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) Baltimore Md

20 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

Informant Eugene A Henry

(Address) 1236 W Gay St

Filed 1929 19 Harry Johns M Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1-27, 19..., to Oct 4/29, 19..., that I last saw him alive on Oct 3/29, 19..., and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows: Chronic [redacted] endocarditis.

Contributory (Secondary) Cystitis (duration) 1 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [redacted], M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 8 1929
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

Spec.—1-12-23—M&T—500 Bks.

E 49827

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 49827

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Provident Hosp. 18-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie M Chase

(a) RESIDENCE No. 898 Boyd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 1929

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	2	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balt. Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Friend & Family

(Address)

Filed Oct 7 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1929, to Oct 5, 1929, that I last saw h[illegible] alive on Oct 5, 1929, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows: Acute Gastro-Intestinal Indigestion

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Geo. MacDonald M. D.

, 19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Oct 7 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 3224 Schroeder St

Cor.—12-9-25—A Co.—200 Bkn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

9828

CERTIFICATE OF DEATH.

× 188-103

REGISTERED NO. E 49828

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie A Stone

(a) RESIDENCE NO. Glenburnie St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry D Stone

6 DATE OF BIRTH (month, day, and year) Dec 6 1875

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Benfield Md

PARENTS

10 NAME OF FATHER Thomas Wade

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Stallings

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs Harry D Stone

(Address) Glenburnie Md

Filed OCT 7 - 1929

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Contusion Pul. Vessels while riding in auto it collided with another

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tract Pelvis Fracture Femur

(duration) yrs. mos. ds.

10/ (Signed) G. J. Frazier M. D.

7, 1929 (Address) (Coroner) 7 Hyson & Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baldwin A. & Co. Date of Burial Oct 8 1929

20 UNDERTAKER John F Denny ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49829

CERTIFICATE OF DEATH

90 E 49829

1-PLACE OF DEATH

City of Baltimore: (No. Walbrook Ave (Cutoff) Letterman St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis J. Snidler

(a) RESIDENCE NO. 2016 N. Smallwood St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Snidler

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Antoine

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Antoine

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant
(Address)

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

7 - 1929 ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Leitch M. D.

Oct 5 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Mt Olivet Cemetery	Oct 9 1929
20 UNDERTAKER	ADDRESS
Koch Bros	1129 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

49830

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49830

CERTIFICATE OF DEATH.

90 V

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument & Rutland ST. 3-5 WARD)

2-FULL NAME Mrs. Anna Fischer

(a) RESIDENCE No. 4 S. High Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joseph Fisher

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 64 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jacob Lewis 1429 Eutaw St

15 Filed 10-7-1929 . 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 4 - 1929

17

I HEREBY CERTIFY, That I attended deceased from 9/25 . 1929 . to 10/4 . 1929 .

that I last saw her alive on 10/4 . 1929 .

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Intra-Cranial Hemorrhage

Apoplexy - Left Hemiplegia

Hypertension (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis Hypertension arteriosclerosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) B. F. Cohen M. D.

10/7, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Cy

DATE OF BURIAL 10/7 1929

UNDERTAKER Jacob Lewis 1429 Eutaw St

ADDRESS

...c.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49831 | CERTIFICATE OF DEATH | 44 E 49831

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 9446

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 33rd & Calvert St ST., WARD)

2—FULL NAME Christian Snyder

(a) RESIDENCE NO. 2717 Fremont ST., Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Snyder

ATE OF BIRTH (month, day, and year) June 3, 1869

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	60	4	2	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer

IRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Conrad Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Ritz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Amelia Snyder

(Address) 2717 Fremont Ave

Filed ... G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5/27

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1927, to Oct 5, 1927, that I last saw h.im alive on Oct 5, 1927 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Has been vomiting for past 3 days & could keep nothing on stomach. Has had large amount of blood in bowels. Has apparently been obstipated

(duration) yrs. mos. 2 5 ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis W. Luck, M. D.

Oct 5th 1927 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 8 1927
20 UNDERTAKER	ADDRESS
Hughes & Jones Inc	1 N. Broadway

Cor.—10-10-29—A Co.—100 Bks.

Radecke

HEALTH DEPARTMENT—CITY OF BALTIMORE

'E 49832

CERTIFICATE OF DEATH

62

'E 49832

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute

City of Baltimore: (No. Hopkins Hospital St., 1-3 Ward)

2-FULL NAME Lorraine Radecke

(a) RESIDENCE NO. 2622 Fait Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep 5/29

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Edward Radecke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Bertha Gostonski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Mother
(Address) 2622 Fait Ave

15 Filed ....., 19.... CHAS. E. JONES, M. D. Registrar

1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Suffocation-Enlarged Thymus Gland (Congenital?)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. K. Cain, M. D.

10/7/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cet	7 1929
20 UNDERTAKER	ADDRESS
John N. Weber	401 S. Chester St

...ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49833

CERTIFICATE OF DEATH

31 E 49833

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 18-16

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Hebron

(a) RESIDENCE NO. 726½ W. Franklin ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1908

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Hebron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hebron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records
(Address)

Filed OCT 7 - 1929 ...STAMPED... JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1929, to Oct. 3, 1929, that I last saw him alive on Oct. 3, 1929 and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) ..... M. D.

10-4, 1929 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon	Oct 19 29
19a UNDERTAKER Mrs. M. A. Elliott	ADDRESS 1725 Eastland ave

...—2-29-28—L. F. S.—500 Blks.

49834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

148 ✓ E 49834

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Mc Cullough St.) 2 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosie Sharpen

(a) RESIDENCE NO. 1211 Mc Cullough ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Sharpen

6 DATE OF BIRTH (month, day, and year): Dec. 5 1895

7 AGE: 34 Years 35 | Months 8 | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

Informant: Mary Smith

(Address) 1211 Mc Cullough St.

Filed 7 1929 19 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929, to Oct 5, 1929, that I last saw her alive on Oct 5, 1929 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

21 Lung Disease Pneumonia

Edampsia Puerperal

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles H. Hancock, M. D.

Oct 7 1929 (Address) 712 S. Bway, Balt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. DATE OF BURIAL: Oct 8th 1929

20 UNDERTAKER: Wm P. G. Elliott ADDRESS: 1225 Ashland Ave

...—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49835

CERTIFICATE OF DEATH

46 ✓

E 49835
REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Baltimore City Hosp ST. 18-No WARD)

2—FULL NAME Rosa Vander

(a) RESIDENCE NO. 834 W. Lexington ST., WARD
(Usual place of abode)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	37			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) (State or country) South Carolina

0 NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

2 MAIDEN NAME OF MOTHER Carolina Unknown

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Record
(Address)

Filed ... 19... C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4/29

17 I HEREBY CERTIFY, That I attended deceased from 6/11/29, 1929, to 10/4, 1929, that I last saw h[illegible] alive on 10/4, 1929 and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown (duration) ... yrs. mos. 2 da.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

10/5. 1929 (Address) Balto. City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-7 1929
20 UNDERTAKER Daniel Eaton	ADDRESS 916 Rd

...ec.—2-29-28—L. F. S.—500 Blks.

E 49836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 49836

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2354 Annapolis Av ST. 37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Thomas

(a) RESIDENCE NO. 2354 Annapolis Av ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 1878

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) Bowie
(State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

Informant Annie Thomas

(Address) 2354 Annapolis Av

Filed 10-7-1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-29

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to Oct 4, 1929, that I last saw h[illegible] alive on Oct 3, 1929 and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/5/1929 (Address) 912 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-7 1929
20 UNDERTAKER D. Frank Tarbert	ADDRESS Balto

...—2-29-28—L. F. S.—500 Blks.

E 49837 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49837.

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

ITY OF BALTIMORE: (No. Balto Md ST., 11-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jessie Edwards

(a) RESIDENCE NO. 910 Jenkins Alley ST., WARD
(Usual place of abode)

ngth of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	Separated

f married, widowed, or divorced HUSBAND of (or) WIFE of

ATE OF BIRTH (month, day, and year) 1879

GE Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
50?			

CCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

IRTHPLACE (city or town) State or country) S. Carolina

0 NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records

(Address) Balto City Hospts.

Filed 10-7-1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-2-29

17

I HEREBY CERTIFY, That I attended deceased from 7-27, 1927 to 10-2, 1929

that I last saw h.. alive on 10-2, 1929

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis with Deterioration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Hampson Jones M. D.

10/3, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-7 1929
20 UNDERTAKER Daniel Corbin	ADDRESS 946 Pa ave

...ct.—2-29-28—L. F. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

49838

CERTIFICATE OF DEATH

E 49838

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

ITY OF BALTIMORE: (No. ST. 18-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Oscar Alexander

(a) RESIDENCE NO. 837 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth?— yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

ATE OF BIRTH (month, day, and year) 1877?

GE	Years	Months	Days	If LESS than 1 day,...hrs. or...min.
52 ?				

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

IRTHPLACE (city or town) (State or country) New Orleans Louisiana

0 NAME OF FATHER Henry Alexander

1 BIRTHPLACE OF FATHER (city or town) New Orleans (State or country) Louisiana

2 MAIDEN NAME OF MOTHER Jane ?

3 BIRTHPLACE OF MOTHER (city or town) New Orleans (State or country) Louisiana

Informant Records of (Address) BALTIMORE CITY HOSPITALS

Filed ..., 19 ... Registrar

1929 C. HAMILTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5-29

17 I HEREBY CERTIFY, That I attended deceased from 5-23, 1929, to 10-5, 1929, that I last saw him alive on 10-5, 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Parenchymatous

(duration) 4? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Edema?

Arteriosclerosis (duration) Duration? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home Here

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & C. Autopsy

(Signed) Harris M. McClean, M. D.

10-6, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	10-7-1929
20 UNDERTAKER	ADDRESS
Dennis Eaton	Reas

Spec.—2-29-28—L. F. S.—500 Blks.

John C Pickel

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49839

CERTIFICATE OF DEATH

44 ✓

REGISTERED NO. E 49839

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 E North ave ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. John C Pickel

(a) RESIDENCE NO. 1621 E North ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 6 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

If married, widowed, or divorced, HUSBAND of (or WIFE of) Matilda Pickel

DATE OF BIRTH (month, day, and year) March 6th 1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	6	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John Pickel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Remp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mamie Pickel

(Address) 1621 E North ave

Filed ....., 19 C. HAMILTON JONES, M. D. Registrar

F - 1925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5th 1925

17 I HEREBY CERTIFY, That I attended deceased from Sept 1- 1925 to Oct 5- 1925

that I last saw h[illegible] alive on Oct 5- 1925

and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, liver

(duration) yrs. 3 mos. + ds.

CONTRIBUTORY (Secondary) Hypernephroma, chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms & Physical signs

(Signed) L. W. Pauls, M. D.

10-6- 1925 (Address) 1117 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 8th 1925
20 UNDERTAKER	ADDRESS
George Schulling & Sons	1130 Monument

...ec.—2-29-28—L. F. S.—500 Bks.

49840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E. 49840

1—PLACE OF DEATH Baltimore City Hospitals (T. B.) REGISTERED NO. 6

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Rathell (Wilson L Rathell)

(a) RESIDENCE NO. 42 E. York st. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) ~~1869~~ March 1864

6 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~65~~ 60	6	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER ~~George Swann~~ Joseph Rathell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ~~Mary Swann~~ Hodges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Records

(Address)

Filed OCT 1 - 1929 C. Hudson Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1929, to Oct. 2, 1929

that I last saw him alive on Oct. 2, 1929

and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & lab.

(Signed) [signature] M. D.

10-2, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	10/1 1929

20 UNDERTAKER E. J. Hennessy Inc - 1388 E. Lafayette Ave

ADDRESS

...c.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

19841

CERTIFICATE OF DEATH

90 ✓

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS 54

REGISTERED NO. E 19841

ITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Squirrel

(a) RESIDENCE NO. 608 Hubbard ST., ... WARD
(Usual place of abode)

ngth of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

If married, widowed, or divoreed
HUSBAND of ?
(or) WIFE of

ATE OF BIRTH (month, day, and year) ?

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
7				

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook ?

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

IRTHPLACE (city or town) ?
(State or country) Md.

0 NAME OF FATHER ?

1 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

2 MAIDEN NAME OF MOTHER ?

3 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

Informant Geo. Isel

(Address) ...TIMORE CITY HOSPITALS

...ed. OCT 7 - 1929 H. Holton Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4/29

17 I HEREBY CERTIFY, That I attended deceased from 8-31, 1929, to 10-7, 1929,

that I last saw h...m alive on 10-7, 1929

and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum, Coma

about 6 wks.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic; Arteriosclerosis; Hypertension (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? P.C.; Lab.; Autopsy

(Signed) Warren H. McLean, M. D.

10-6, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	10-7 1929
20 UNDERTAKER	ADDRESS
B. Frow Wright	1218 N. Eden St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 49842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49342

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 N Linwood Ave | WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Wansch

(a) RESIDENCE NO. 833 N Linwood Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE: Nicholas Wansch

DATE OF BIRTH (month, day, and year): Aug 4 1870

AGE: 59 — Years: 58. Months: 2 Days: 1 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Sebastian Barducci

(Address) 3729 Elmora Ave

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1929, to Oct 5, 1929, that I last saw her alive on Oct 5, 1929, and that death occurred, on the date stated above, at 6 40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Tubular Kidney Disease

CONTRIBUTORY (Secondary): Senile Arteriosclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D Fitch M. D.

Oct 6, 1929 (Address) 936 Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct 7 1929

20 UNDERTAKER: John Ulrich ADDRESS: 2008 Orleans

Spec.—1-10-21—M&T—1500 Bks.

E 49843 HEALTH DEPARTMENT—CITY OF BALTIMORE

Betts

CERTIFICATE OF DEATH.

74-0.9

E 49843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3116 N. Calvert ST. 12-50 WARD)

2-FULL NAME Sallie T. Betts

(a) RESIDENCE NO. 3116 N. Calvert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (a) WIFE of Clayton Mayo Betts

6 DATE OF BIRTH (month, day, and year) Aug 17-1843

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or min.
86	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER John G. Robinson

11 BIRTHPLACE OF FATHER (city or town) Washington D.C.

12 MAIDEN NAME OF MOTHER Eliza Carles

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.

14 Informant Carrie B Jones

(Address) 3116 N. Calvert st.

15 Filed OCT - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 21. 1927. to Oct 5th 1929.

that I last saw her alive on Oct 5th 1929

and that death occurred, on the date stated above, at 10-27 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. E. Rinehard, M. D.

Address 3201 N. Charles st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Oct 8/29 19

20 UNDERTAKER Chas. E. Tomich ADDRESS 802 Madison ave

...ec.—2-29-28—L. F. S.—500 Blks.

E 49844 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-901 E 49844

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto. City Hosp. ST. 3-4 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Maxwell

(a) RESIDENCE NO. 1614 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

10 NAME OF FATHER Alex. Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Ruth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

Informant Hospital Record

(Address)

Filed 7 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2/29

17 I HEREBY CERTIFY, That I attended deceased from 10/1, 1929, to 10/2, 1929, that I last saw h...live on 10/2, 1929 and that death occurred, on the date stated above, at 4/45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertrophic prostatitis.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Thompson, M. D.

10/3, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS
Commissioner Health.	OCT 7 - 1929

...HAMILTON JONES, M

Spec.—1-10-21—M&T—1500 Blks.

E 49845

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49845

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 948 E. Bennett Place ST. 16-N WARD)

2-FULL NAME George W. Mitchell

(a) RESIDENCE No. 948 E. Bennett Place ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Mitchell

6 DATE OF BIRTH (month, day, and year) Feb 22 71

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer) Market

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER W. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Sarah Dennison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Rose Mitchell

(Address) 948 Bennett Place

15 Filed 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 11 th. 1929. to Oct 4 th. 1929. that I last saw him alive on Oct 4 th. 1929. and that death occurred, on the date stated above, at 1000 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis acute

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Dilatation of heart

(duration) yrs. 2 mos. 17 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Anasarca

(Signed) V Kin Williams M. D.

, 19 (Address) 941 Cumberland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Oct 7 1929

20 UNDERTAKER W M Rouleau — ADDRESS 2235 N Mta

Spec.—8-16-29—L. F. S.—100 Bks.

E 49846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49846

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 927 Bonney ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily Jane Williams

(a) RESIDENCE NO. 927 Bonney ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): July 4 1845

AGE: Years 84 Months 2 Days 29 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Stephen Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: Geo. J. Williams

(Address) 927 Bonney St.

FILED OCT 7 - 1929

C. HARRY JONES, M. D. Registrar

Dep

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1924, to Oct 3rd, 1924, that I last saw her alive on Oct 2nd, 1924, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

CONTRIBUTORY (Secondary): Myocarditis, and Interstitial Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R J Stanley M. D.

10/5, 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: John Wesley Cem. DATE OF BURIAL: Oct 7 1924

20 UNDERTAKER: Samuel Hemsley ADDRESS: 1132 Mad

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 ✓

E 49847

CERTIFICATE OF DEATH

E 49847

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

2—FULL NAME Joseph Sirio.

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred about 16 yrs. — mos. — ds. How long in U. S., If foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of single

ATE OF BIRTH (month, day, and year) Sept. 4 1903

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	1	2	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

IRTHPLACE (city or town) State or country) Italy

0 NAME OF FATHER Joseph Sirio

1 BIRTHPLACE OF FATHER (city or town) — (State or country) Italy

2 MAIDEN NAME OF MOTHER Rosa Simone

3 BIRTHPLACE OF MOTHER (city or town) — (State or country) Italy

Informant Mt Hope Retreat

(Address) Mt Hope Retreat.

Filed ... 19 ... Registrar

7 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6. 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924 to Oct 6, 1929.

that I last saw h alive on Oct 5 1929

and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(Syphilis)

(duration) 9 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Kahn

(Signed) Milton P. Hall, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct 8 19 29
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Lightst.

...ec.—2-29-28—L. F. S.—500 Bks.

E 49848 6

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49848

CERTIFICATE OF DEATH

1929

1—PLACE OF DEATH

REGISTERED NO.

...ITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Cramblitt

(a) RESIDENCE NO. 1918 Frederick ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

...ATE OF BIRTH (month, day, and year): April 9, 1862 4-9-62

...GE	Years	Months	Days	If LESS than 1 day,...hrs. or...min.
	67 ~~68~~	5	27	

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

...IRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Thomas Cramblitt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catharine Sisco

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

Filed ..., 19 1929 ...ron Registrar

C. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 - 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 6, 1929,

that I last saw him alive on Oct 6, 1929

and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

My Benign Prostatic Hypertrophy

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Myocardial Failure

(duration) ...yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 4, 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Dames, M. D.

10/6, 1929 (Address) Johns Hopk. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: Oct. 8 1929

20 UNDERTAKER: Joseph B Cook

ADDRESS: 1003 West Baltimore St

...sc.—2-29-28—L. F. S.—500 Blks.

E 49849

229161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-081

E 49849

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2—FULL NAME Edward V Lundberg

(a) RESIDENCE NO Winterhaven Florida ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 3 weeks yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Florence C. Lundberg

ATE OF BIRTH (month, day, and year) Unknown January 10, 1872

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	8	27	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer & Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer International Fruit Corp.

IRTHPLACE (city or town) (State or country) Sweden

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed ...., 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-7-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Oct 7, 1929, that I last saw him alive on Oct 7, 1929 and that death occurred, on the date stated above, at 440 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florida

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Fred M Ellsworth M. D.

10/7, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Pleasant City, Florida	Oct 7, 1929
20 UNDERTAKER Lloyd J Cook	ADDRESS 1003 N. Calvert St.

C. HAMPSON [illegible]

Spec. 2-29-28—L. F. S.—500 Bks.

E 49850 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 49850**

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. 1622

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Beach

(a) RESIDENCE NO. 2000 Rayner Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowered

If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Beach

6 DATE OF BIRTH (month, day, and year) Oct 31st 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER William Beach

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Grey

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

Informant Harry Beach

(Address) 2004 Rayner Ave

Filed 1929 C. HAMPSON JONES, M. D. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 19 , to Oct 5, 1929 that I last saw h/m alive on Oct 5, 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, General.
Nephritis, Chronic

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia, Chronic, Myocardial Insuf. (duratinn) yrs. mos. 21 ds.

18 Where was disease contracted if not at place nf death? Home

Did an operatinn precede death? No Date of

Was there an autopsy? No

What test cnnfirmed diagnosis? Clinical & Laboratory

(Signed) W. H. Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature nf Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Oct 8th 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul st

...—2-29-28—L. F. S.—500 Blks.

E 49851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

75.00

E 49851

1—PLACE OF DEATH

REGISTERED NO. 16-37

ITY OF BALTIMORE: (No. Baltimore City Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Raymond

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	47			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) State or country) Mass.

0 NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Record
(Address)

Filed 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5/29

17 I HEREBY CERTIFY, That I attended deceased from 9/16, 1929, to 10/5, 1929, that I last saw h~~im~~ alive on 10/5, 1929 and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

Sequelae Left Foot

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Lumpkin, M. D.

10/6, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hyer-Mass	10/7 1929
20 UNDERTAKER William Cook	ADDRESS 1217 St Paul

...ec.—2-29-28—L. P. S.—500 Blks.

E 49852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100 1901 E 49852

1—PLACE OF DEATH

REGISTERED NO.

ITY OF BALTIMORE: (No. Baltimore City Hosp. ST., No-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence Hopkins

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) State or country) Maryland

0 NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Hospital Record
(Address)

Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28/29

17 I HEREBY CERTIFY, That I attended deceased from 6-16, 1916, to 9/28, 1929

that I last saw him alive on 9/28, 1929

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Senility - Arteriosclerosis.
Chronic infectious arthritis.

(duration) Unknown

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin, M. D.

10/4, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 10/ 1929

20 UNDERTAKER John J. Kelly Sons

ADDRESS 1318 Light

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49853

CERTIFICATE OF DEATH

90

E 49853

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2926 Clifton Pl St. 15-61 Ward)

2-FULL NAME Frank Sheeler

(a) RESIDENCE NO. 2926 Clifton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Jennie Sheeler
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov 25th 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Sheeler

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Rina Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country)

14 Informant Clarence Sheeler
(Address) 3287 Piedmont

15 Filed ..... 19..... C. HAMPSON JONES M. D.
Registrar
Dep.

1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 5th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Hollick, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Cemetery	Oct 8th 1929
20 UNDERTAKER Martin Fahey & Sons	ADDRESS 1827 W Baltimore

Cor.—10-10-29—A Co.—100 Bks.

E 49854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

160 **E 49854**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1222 Clinton St. 26-1 Ward)

2-FULL NAME Jake D Jacobs.

(a) RESIDENCE NO. 1222 Clinton St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leavington Jacobs.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Nettie Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Georgia

14 Informant Leavington Jacobs.
(Address) 1222 Clinton St

15 Filed 1929 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Icterus

(duration) 1 yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) H. D. Eades, M. D.
, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Oct 8 1929
20 UNDERTAKER George W Zirkin	ADDRESS 1737 E Lanvale

Cor.—12-9-25—A Co.—200 Bks.

E 49855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 31

E 49855

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2604 Rogers Avenue St. 27-55 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helene LaRue Noel

(a) RESIDENCE NO. 2604 Rogers Avenue St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? 33 yrs. 11 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct-21-1895

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Edgar M. Noel

11 BIRTHPLACE OF FATHER (city or town) Charlottsv

(State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah LaRue

13 BIRTHPLACE OF MOTHER (city or town) Phila.

(State or country) Penna.

14 Informant Mrs. Sarah E. Noel (mother)

(Address) 2604 Rogers Avenue

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

10/7, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial Oct-9-29 19

20 UNDERTAKER EWART & MOWEN COMPANY ADDRESS

spec.—2-29-28—L. F. S.—500 Bks.

E 49856

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 49856

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE (No. 711 Resivoir ST. 13 20 WARD)

2—FULL NAME John Jacob Snyder

(a) RESIDENCE NO. 711 Resivoir ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 69 yrs. 2 mos. 22 ds. How long in U. S., if foreign birth 69 yrs. 2 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Rosalind Snyder

ATE OF RIRTH (month, day, and year) July-14-1860

GE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	22	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

RTHPLACE (city or town) Baltimore
State or country) Maryland

0 NAME OF FATHER Henry Snyder

1 BIRTHPLACE OF FATHER (city or town) Shrewsbury
(State or country) Penna

2 MAIDEN NAME OF MOTHER Susanne Graham

3 BIRTHPLACE OF MOTHER (city or town) Paisley
(State or country) Scotland

Informant Wm. Chas. L. Snyder (Son)

(Address) 3401-N-Calvert St.

Filed OCT - 1929 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6-29

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to October 6, 1929, that I last saw h[illegible] alive on Oct. 5, 1929, and that death occurred, on the date stated above, at 1 00 A- m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

CHR. NEPHRITIS

(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John S. Jones, M. D.

, 19 (Address) 1129 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Oct 8 1929.
20 UNDERTAKER	ADDRESS
Stewart Mowen Co	Balto.

...—2-29-28—L. F. S.—500 Bks.

E 49857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8 E 49857

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (Franklin Square Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth C. Pfitzner

(a) RESIDENCE NO. 412 E. Fairfield ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) — — 1923

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	6	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto. Md.

NAME OF FATHER George Pfitzner

BIRTHPLACE OF FATHER (city or town) (State or country)

MAIDEN NAME OF MOTHER Elsie Turner

BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant

(Address)

Filed ... 19...

C. HAMPSON JONES M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6/29.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1929, to Oct. 6, 1929.

That I last saw her alive on Oct. 6, 1929

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Scarlet Fever 2 mos ago.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. L. Smith M. D.

(Address) 129 W Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 10/8 1929

20 UNDERTAKER J. Wesley Jones

ADDRESS 3 S Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49858

CERTIFICATE OF DEATH

E 49858

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4304 Granada Ave. ST. 28-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lizzie Horn

(a) RESIDENCE NO. 4304 Granada Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 1 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Horn

DATE OF BIRTH (month, day, and year) August 21, 1853

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Martin Heyn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Klingelhoefer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant Rev. J. Kemp Horn
(Address) 5024 Gwynn Oak Ave.

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Oct 6, 1929

that I last saw h[illegible] alive on Oct 6, 1929

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage
duodenal Ulcer Malignancy?

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ulcer of Duodenum

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? observation

(Signed) Joseph A. Jackson M. D.

(Address) 320 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Oct. 8, 1929
20 UNDERTAKER Mary V. Wilke, 1530	ADDRESS Pennsylvania Ave

...c.—2-29-28—L. F. S.—500 Blks.

E 49859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49859

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union memorial Hospital 33rd & Calvert ST., 10-28 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna May Seikel

(a) RESIDENCE NO. 1925 Christian ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 14 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) March 21, 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	6	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER Samuel Seikel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER. Julia Gledmacher

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

Informant Julia A. Seikel

(Address) 1925 Christian St.

FILED Oct. 8, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 24, 1929 to October 6, 1929

that I last saw h.er alive on October 6, 1929

and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Syphilis

CONTRIBUTORY (Secondary) — Bronchopneumonia (duration) 0 yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? Hom - Home. (duration) 0 yrs. 1 mos. 14 ds.

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? + Wassermann on blood + spinal fluid

(Signed) Richard T. Shackelford M. D.

Oct. 6, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Oct. 8, 1929

20 UNDERTAKER Henry A. Wittle — ADDRESS 53 W. Lanvale

Cor.—10-10-29—A Co.—100 Bks.

E 49860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49860

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 914 E. Lombard St., 3-E Ward)

2-FULL NAME (Kojtow) John Gross

(a) RESIDENCE NO. 914 E Lombard St., _____ Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 25 yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor Ob
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithvania

PARENTS

10 NAME OF FATHER F. Gross

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER A. Svetikit

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithvania

14 Informant Elizabeth Gross
(Address) 416 Fayow st

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Dec death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

CONTRIBUTORY (Secondary) Cirrhosis (duration) 6 yrs. 1 mos. ___ ds.

_____ (duration) ___ yrs. ___ mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What findings confirmed diagnosis? History

(Signed) M. Gladis M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Independ	Oct. 8, 1927

20 UNDERTAKER John Grabliauckas

ADDRESS 427 S. Bond St.

E.B.

...—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49861

31 E 49861

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Brown

(a) RESIDENCE NO. 1437 W. Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Preston Brown

DATE OF BIRTH (month, day, and year): Feb 3 1904

AGE: Years 25 | Months 6 | Days 2 | If LESS than 1 day ... hrs or ... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

BIRTHPLACE (city or town) (State or country): N.C.

10 NAME OF FATHER: Wm Harrell

11 BIRTHPLACE OF FATHER (city or town) (State or country): NC

12 MAIDEN NAME OF MOTHER: Lola Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): NC

Informant: Preston Brown

(Address) 1437 W. Lanvale

Filed ... 1929 ... 19 ... H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1929, to Oct 5, 1929, that I last saw her alive on Oct 5, 1929, and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine, Complicated by Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Chronic Nephritis Uraemia (duration) ? yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. ? mos. ds.

Did an operation precede death? yes Date of May 10, 1929

Was there an autopsy? (yes) What test confirmed diagnosis? Clinical & Laboratory

(Signed) W. S. Draper M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown MD — DATE OF BURIAL: 10/8 19 29

20 UNDERTAKER: Lewis Greenwald 58 N. Eutaw

Spec.-7-17-26—A Co.—200 Bks.

E 49862 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 ✓ **E 49862**

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 542 Orchard St. 1727 Ward) REGISTERED NO.

2-FULL NAME Harriet Lavinia Payne

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 542 Orchard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. W. Payne

6 DATE OF BIRTH (month, day, and year): Sept. 8, 1864

7 AGE: Years 65 Months 10 Days 27

IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Marys Co. Md

PARENTS

10 NAME OF FATHER: James Smith

11 BIRTHPLACE OF FATHER (City or town) (State or country): St Marys Co. Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town) (State or country): St Marys Co. Md

14 Informant: Harvey Payne (Son)

(Address) 542 Orchard St

15 Filed OCT 8 - 1929

16 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 5 1929

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to Oct 5, 1929, that I last saw h[illegible] alive on Oct 4, 1929, and that death occurred, on the date stated above, at 4.30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Mesocardiosis (duration) yrs. 3 mos. da.

Exhaustion (duration) yrs. mos. 14 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Data of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Shuttleworth M. D.

10/7, 1929 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt. Auburn Cem Date of Burial Oct 8 1929

20 UNDERTAKER: Samuel H. Ensley

ADDRESS 577 Biddle

...e.—2-29-28—L. F. S.—500 Blks. # 1714 N. Caroline St. Dr Landenwood

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49863 — 90 E 49863

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

...ITY OF BALTIMORE: (No. 331 Fayette ST. 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Walter

(a) RESIDENCE NO. 299 S. Eutaw ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Walter

...ATE OF BIRTH (month, day, and year) Dec. 7th 1857

...GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	9	29	

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

...RTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Geo. Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Wm. H. Walter

(Address) 299 S. Eutaw St

...Filed ... 28 - 1928 ... HAMPSON JONES, M. D.
...er ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6th 1928

17 I HEREBY CERTIFY, That I attended deceased from Sept 25 1928, to Oct 6 1928,

that I last saw him alive on Oct 6 1928,

and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Val. Insuff. Chronic Nephritis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John N. Henderson, M. D.

, 19 (Address) 1714 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 9th 1928
20 UNDERTAKER	ADDRESS
E. W. Hesselbart	853 W. Baltimore St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49864

CERTIFICATE OF DEATH.

66 ✓ E 49864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4101 Northern Parkway St. 27-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Plumhoff

(a) RESIDENCE NO. 4101 Northern Parkway St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Plumhoff

DATE OF BIRTH (month, day, and year) Jan. 16, 1880

AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	49	8	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer Henry D. Plumhoff

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Henry D. Plumhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Ortman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Mrs. Fredy Plumhoff

(Address) 4101 Northern Pkwy

Filed Oct 8 1929 19 H. AMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1929, to Oct 6th, 1929.

that I last saw him alive on Oct 4th, 1929

and that death occurred, on the date stated above, at 6 30 p m.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Delerium Tremens

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Edward Blanchard, M. D.

10/6, 1929 (Address) Govans Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 8 1929
20 UNDERTAKER: Frederick Loraah & Sons	ADDRESS: Fullerton

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49865

E 49865

CERTIFICATE OF DEATH Tinker 188-78

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Gr Ds Hosp St., 9-17 (Ward)

2-FULL NAME Franklin Duke Tinker

(a) RESIDENCE NO. Perry Hall St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Nov 28 1918

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	10	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bridgeport
(State or country) Conn.

PARENTS

10 NAME OF FATHER Franklin M. Tinker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) St Johns Bury Vt.

12 MAIDEN NAME OF MOTHER Frances E Duke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Berlin N. Y.

14 Informant Franklin M. Tinker
(Address) Perry South Md

Filed 1929 THOMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple fract (Co. Comm) with hemorrh - hit & run auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic shock

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Perry Hall & Belair Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L. Mann, M. D.

10/8 1929 (Address) 2929 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Michaels Lutheran Cem.	Oct 9 1929
20 UNDERTAKER	ADDRESS
Frederick Lauchheimer	Fullerton

...—2-29-28—L. F. S.—500 Blks.

E 49866

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49866

CERTIFICATE OF DEATH

X 100-001

1—PLACE OF DEATH

REGISTERED NO. 16-22

CITY OF BALTIMORE: (No. 1403 Mosher ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harrison Creek

(a) RESIDENCE NO. 1403 Mosher ST. Mosher WARD Chesterfield Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Baby

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 12 1924

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	25	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Chester field md.

10 NAME OF FATHER Preston Creek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chester field md

12 MAIDEN NAME OF MOTHER Viola Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chesterfield

Informant Viola Creek

(Address) 1403 Mosher St

Filed ... 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1929, to Oct 6, 1929, that I last saw him alive on Oct 6, 1929 and that death occurred, on the date stated above, at 11:59 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Test

(Signed) Luther R. Frith, M. D.

10-7-1929 (Address) 1137 Thicket

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chesterfield C.C.	Oct. 8 1929
20 UNDERTAKER Sam'l E. Chase Funeral Home	ADDRESS 1400 Mosher

Spec.—1-12-23—M&T—500 Blks.

E 49867

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49867

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH West Baltimore General

CITY OF BALTIMORE: (No. 16-23 ST. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgiana Hayden

(a) RESIDENCE NO. 916 N. Calvert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): M ~~Widowed~~

If married, widowed, or divorced (HUSBAND of or) WIFE of: Boyd Hayden

DATE OF BIRTH (month, day, and year): Jan. 30 1892

AGE: Years 38 | Months 8 | Days 7 | If LESS than 1 day, hrs. or min

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Louis Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Celia Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Mary B. Thomas

(Address)

Filed 10-8-1929 WM. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from 9/16, 1929, to 10/7, 1929

that I last saw h~~e~~alive on 10/7/29

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs 9 mos ds.

CONTRIBUTORY (Secondary) Shock (duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/5/29

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical operative findings

(Signed) J. F. Castagna, M. D.

10/7, 1929 (Address) West Balto. General

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pilgrim Cem. DATE OF BURIAL: Oct 10 1929

20 UNDERTAKER: Wm. H. Crowther ADDRESS: Waverly

Spec.—2-29-28—L. F. S.—500 Bks.

E 49868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49868

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1114 Hasselberger (STREET AND NUMBER) REGISTERED NO. 22-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Belle Arrington

(a) RESIDENCE NO. 1114 Hasselberger (Usual place of abode) WARD

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Arrington

6 DATE OF BIRTH (month, day, and year) January 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant Howard Starr

(Address) 1413 Eutaw Place

OCT 8 - 1929

S. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5/29

17 I HEREBY CERTIFY, That I attended deceased from 10/1/29, to 10/5/29, that I last saw h alive on 10/5/29, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) about yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical - microscopical

(Signed) Geo. Dorsey, M. D.

10/7/29 (Address) 708 S Chapel St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Oct 9 1929
20 UNDERTAKER	ADDRESS
Jno. H. Hawkins Son	1400 Madison

pec.—1-12-23—M&T—500 Bks.

E 49869 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓90 E 49869

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home for Aged 2054 ST. Dolfield WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Farbinski

(a) RESIDENCE NO. Rimdale ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of David Farbinske

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
77		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) L

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Last Home
(Address)

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/7 1929 to 10/7 1929, that I last saw h alive on 10/7 1929, and that death occurred, on the date stated above, at 1.10 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

10/7 1929 (Address) 2030 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale DATE OF BURIAL 10/9 1929

20 UNDERTAKER Jack Levin ADDRESS 1139 E Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49370

CERTIFICATE OF DEATH.

E 49370

1-PLACE OF DEATH Maryland Gen Hosp

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Painter Jr

(a) RESIDENCE NO. Perryville Md ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): June 16 1924

7 AGE: 5 Years 3 4 Months Days 22 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md

10 NAME OF FATHER: Samuel B. Painter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Thelma Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Perryville Md

14 Informant (Address): Hospt Records

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1929, to Oct 7, 1929, that I last saw him alive on Oct 7, 1929, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronch

(duration) ..... yrs. ..... mos 1/2 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Dm

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Thos Hampson Jones, M. D.

(Address) Chas Jas Harper

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Perryville, Md. DATE OF BURIAL: Oct 11 1929

20 UNDERTAKER: Chas. Patterson ADDRESS: Perryville Md

ec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49871
1—PLACE OF DEATH

E 49871
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 4024 Walbad ST. 10-7 WARD)

2—FULL NAME George Jacobs

(a) RESIDENCE NO. 4024 Walbad ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

If married, ~~widowed, or divorced~~
~~HUSBAND of~~ ~~(or)~~ ~~WIFE of~~ Agnes C Jacobs

6 DATE OF BIRTH (month, day, and year) Aug 29, 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wheelwright
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Not employed

9 BIRTHPLACE (city or town) Germany
(State or country)

10 NAME OF FATHER Peter Jacobs

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaretta Shelter

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

Informant Mrs. Agnes Jacobs
(Address) 4024 Walbad St

Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1929, to Oct 6, 1929
that I last saw h[illegible] alive on Oct 5, 1929
and that death occurred, on the date stated above, at 5-20 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X-ray

(Signed) Wm. A. Thomas, M. D.
Oct. 6, 1929 (Address) 1901 Griffis

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Oct 9 1929

20 UNDERTAKER Geo W Little
ADDRESS 2700 Edmondson Ave

...—2-29-28—L. F. S.—500 Bks.

49372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

15-62-90 ✓ E 49372

1—PLACE OF DEATH

REGISTERED NO.

ITY OF BALTIMORE: (No. 3500 Copley Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emery Healey Purinton

(a) RESIDENCE NO. 3500 Copley Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 15 yrs. - mos. - ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of S. Ola Gates

ATE OF BIRTH (month, day, and year) Sept. 23, 1878

GE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51	0	13	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Mutual Life Ins. Co.

IRTHPLACE (city or town) (State or country) Falls River Massachusetts

0 NAME OF FATHER Alonzo Purinton

1 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

2 MAIDEN NAME OF MOTHER Adelaide Healey

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

Informant Mrs. S. Ola Purinton

(Address) 3500 Copley Road

Filed ..... 19 C. HAMPSON JONES, M. D.

8-192 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6-29

17

I HEREBY CERTIFY, That I attended deceased from 3/1 . 1929. to 10/6 . 1929.

that I last saw him alive on 10/6 . 1929

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arthritis

Myocarditis Chronic

(duration) 1 yrs. 7 mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

Insufficiency (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? 3500 Copley Rd

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Zach. B. Morgan, M. D.

10/7. 1929 (Address) Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	10/10 1929
UNDERTAKER Henry U. Mears & Son	ADDRESS 805 N. Calvert

Cor.—10-10-29—A Co.—100 Bks.

E 49873

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49873

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1309 N. Parrish St. 15-22 Ward)

2-FULL NAME Rozie King.

(a) RESIDENCE NO. 1309 N. Parrish St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Virginia

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Fulton King
(Address) 1309 Parrish St

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Aortic Dilatation Sudden
(duration) yrs. mos.
CONTRIBUTORY (Secondary) Chronic Syphilis
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) Oct 8 '29 Hal Faick, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct 8, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 S Schroeder St

OCT 8 1929 HAMPSON JONES, M. D.

...c.—2-29-28—L. F. S.—500 Blks.

E 49874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-901 E 49874

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. 225 S. Fremont Ave. ST. 22-29 WARD)

2—FULL NAME Phillip C. Guntrum

(a) RESIDENCE NO. 225 S. Fremont Ave. ST., WARD
(Usual place of abode)

ngth of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie A. Guntrum

ATE OF BIRTH (month, day, and year) August 19, 1852

GE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	1	17	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

IRTHPLACE (city or town) Hessen Darmstad
State or country) Germany

0 NAME OF FATHER Unknown

1 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

2 MAIDEN NAME OF MOTHER Unknown

3 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

Informant Mrs. Carrie A. Guntrum

(Address) 225 S. Fremont Ave.

Filed OCT 8 - 1929 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1929, to Oct 6, 1929

that I last saw h. im alive on Oct 6, 1929

and that death occurred, on the date stated above, at 6.25 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Os Lloyd M. D.

10/7. 1929 (Address) 2232 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 9 1929

20 UNDERTAKER Joseph Cook

ADDRESS 1003 West Baltimore St

...c.—2-29-28—L. F. S.—500 Blks.

E 49875 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49875

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-62

CITY OF BALTIMORE: (No. 4106 Dorchester Road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia E. Edmonston

(a) RESIDENCE NO. 4106 Dorchester Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Edmonston

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prince Anne County
(State or country) Maryland

10 NAME OF FATHER James M. Boyd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susanna Hedrick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant Mrs. H. Adele Kelley

(Address) 1909 Deering Ave.

Filed 8-1929 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15th, 19 29 to Oct. 6th, 19 29

that I last saw her alive on Oct 6th, 19 29

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach -
Senility.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Starvation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. P. Boyer, M. D.

10/7, 29 (Address) 3048 W. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 9 19 29

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St

...c.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49876

CERTIFICATE OF DEATH

38V

E 49876

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ..... ST. 1623 WARD)

2—FULL NAME Alexander Waddy

(a) RESIDENCE NO. 1310 Small ..... ST., ... WARD
(Usual place of abode)

ngth of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
ale	Colored	Married

f married, widowed, or divorced HUSBAND of (or) WIFE of Marietta

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work Laborer 040

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) (State or country) Virginia

0 NAME OF FATHER William Waddy

1 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

2 MAIDEN NAME OF MOTHER Jane Coleman

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Records of (Address) Baltimore City Hospitals

Filed OCT 8. 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1929 to Oct. 7, 1929

that I last saw him alive on Oct. 7, 1929

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic Acute

..... (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic Acute

..... (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? None (over)

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. Path. Lab. Autopsy

(Signed) Warren H. McLean, M. D.

10-7, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
White Stone Va	10-8 1929
20 UNDERTAKER	ADDRESS
Barnett Eaton &	916 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

E 49877 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49877

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1437 N. Saratoga ST. 1927 (WARD)

2-FULL NAME Louisa Johnson

(a) RESIDENCE NO. 1437 N. Saratoga ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Harriet Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mercedes Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hattie ... (Address) 1413 W. Saratoga St

15 Filed OCT 8 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 25th, 1929, to Oct 6th, 1929, that I last saw her alive on Oct 6th, 1929, and that death occurred, on the date stated above, at 4.00 P.M.

The CAUSE OF DEATH* was as follows:

Chr. Carcinomatosis

Metastasis.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Leo. N. Lautenbach M. D.

10-7, 1929 (Address) 2218 N. Howard Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-8 1929
UNDERTAKER Diamond Eastern	ADDRESS 746 Park Ave

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49878

CERTIFICATE OF DEATH

90 E 49878

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3105 Weaver ave St. 27-41 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev Howard Moses Ingham

(a) RESIDENCE NO. 3105 Weaver ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	N	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah N Ingham

6 DATE OF BIRTH (month, day, and year) Dec 18 1844

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	84	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Wm A Ingham

11 BIRTHPLACE OF FATHER (City or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Stebbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mrs Sarah Ingham

(Address) 3105 Weaver ave

15 Filed ... 19 ...

OCT 8 - 1929 PM

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1928, to Oct 4, 1929, that I last saw him alive on Oct 6 - 29, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Chronic myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) T. J. Grady, M. D.

10-7. 1929 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Woodlawn	Oct 10 1929
20 UNDERTAKER W M Routson	ADDRESS 2238 N Pine

Spec.—1-10-21 M&T 1500 Bks.

E 49879

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49879

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 106 N Conway ST. 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May J Hardesty

(a) RESIDENCE No. 106 N Conway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Hardesty

6 DATE OF BIRTH (month, day, and year) Sept 18 69

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min.
	80	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm Z Hardesty

(Address) 2109 E Chase St

Filed ....., 19 ..... Register

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1929 to Oct 5, 1929

that I last saw him alive on Oct 5, 1929

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Prolapsus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. C. F. Campbell M. D.

6-7-29 (Address) 644 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Oct 8 1929

20 UNDERTAKER W M Winston

ADDRESS 2233 W Mulberry

...c.—2-29-28—L. F. S.—600 Blks.

E 49880 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-00 E 49880

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

ITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Morgan

(a) RESIDENCE NO. 114 Colvin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

RTHPLACE (city or town) State or country) Maryland

0 NAME OF FATHER Upton Morgan

1 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

2 MAIDEN NAME OF MOTHER Harriet ?

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Record
(Address)

Filed 1929, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/4/29

17 I HEREBY CERTIFY, That I attended deceased from 9/27, 1929, to 10/4, 1929, that I last saw her alive on 10/4, 1929 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Recto vaginal fistula

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) L. A. Pumphrey, M. D.

10/5: 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct 8, 1929
20 UNDERTAKER Mrs Kate R. Williams	ADDRESS 327 N Schroeder St

...ec.—2-29-28—L. F. S.—500 Blks.

E 49331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+49 E 49331

1—PLACE OF DEATH Union Memo. Hosp. 33rd & Calvert St. REGISTERED NO.

CITY OF BALTIMORE: (No. Balt. Md. ST. 430 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Peter Doyle Jr.

(a) RESIDENCE NO. Fork, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~ | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Widowed.

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Doyle (d)

6 DATE OF BIRTH (month, day, and year) June ~~22~~ 8, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
~~62~~	62	9	~~22~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer & h

(b) General nature of industry, business, or establishment in which employed (or employer): unknown.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER Peter Purdue Doyle.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Hayes ~~Kellerman~~ ~~Stotler~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

Informant: Record

(Address)

Filed 1929 C. H. IMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Oct 8, 1929.

that I last saw h... alive on Oct 8, 1929.

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral softening due to Vascular disease. I have specific information from Dr. Chas. Bagley, later I (duration) yrs. 2½ mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Undetermined.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Exam.

(Signed) Samuel McLane Lane, M. D.

Oct 8, 1929 (Address) Union Memorial Hosp. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stephens Cem. Bradshaw 2nd — DATE OF BURIAL: Oct 11 1929

20 UNDERTAKER: D. C. Arthur — ADDRESS: Fork Md.

ec.—2-29-28—L. F. S.—500 Bks.

E 49382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 49382

1—PLACE OF DEATH

REGISTERED NO.

ITY OF BALTIMORE: (No. 2001 Ellsworth ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christian Rehberger

(a) RESIDENCE NO. 2001 Ellsworth ST., WARD
(Usual place of abode)

ngth of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rehberger

ATE OF BIRTH (month, day, and year) June 21 1855

GE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	3	12	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer): Himself

(c) Name of employer

RTHPLACE (city or town) (State or country): Balto

0 NAME OF FATHER Sabastin Rehberger

1 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

2 MAIDEN NAME OF MOTHER Laura Mohr

3 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Elizabeth Rehberger

(Address) 2001 Ellsworth St

Filed 1929, HAMPSON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 19 29 to Oct 5 19 29

that I last saw h alive on Oct 5 19 29 and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Nephritis acute

CONTRIBUTORY (Secondary) acute Cerebral Edema (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore burn

DATE OF BURIAL: Oct 8 1929

20 UNDERTAKER: Philip A Herwig

ADDRESS 2016 Orleans St

ec.—2-29-28—L. F. S.—500 Bks.

E 49883

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 49883

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3530 Esther Place ST., 16-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Dean Lapole

(a) RESIDENCE NO. 3530 Esther Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of none

DATE OF BIRTH (month, day, and year) Sept 16/29

AGE	Years	Months	Days	If LESS than 1 day... hrs. or... min.
			21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Frank Lapole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Iva Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Frank Lapole

(Address) 3530 Esther Place

Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 7, 1929.

that I last saw him alive on Oct 5 1929

and that death occurred, on the date stated above, at 12.55 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) James B Tilton M. D.

10/7, 1929 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount of Rocks Md. DATE OF BURIAL Oct 9 1929

20 UNDERTAKER Philip Herring ADDRESS 2016 Orleans St.

...c.—2-29-28—L. F. S.—500 Blks.

E 49884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 49884

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No.) Balto City Hosp. ST. 12-51 (WARD)

2—FULL NAME John M Cooney

(a) RESIDENCE NO. 315 Wyman Park Drive ST.

(Usual place of abode) WARD

ngth of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Cooney

ATE OF BIRTH (month, day, and year) Feb 28 1874

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	9	

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone operator

(b) General nature of industry, business, or establishment in which employed (or employer) Tel Co

(c) Name of employer

IRTHPLACE (city or town) State or country) Maryland

0 NAME OF FATHER Michael Cooney

1 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

2 MAIDEN NAME OF MOTHER Mary Scanlon

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Hospital Records

(Address)

Filed 1929, 19 HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7/29

17 I HEREBY CERTIFY, That I attended deceased from 9/2, 1929, to 10/7, 1929

that I last saw h[illegible] alive on 10/6, 1929

and that death occurred, on the date stated above, at 4[illegible] a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma left Antrum

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. W. Pumphrey, M. D.

10/7, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct. 10 1929
20 UNDERTAKER	ADDRESS
Fred A Wannemacher	703 Hamm

Spec—12-23-21—E.B.R.S.—400 Blks.

E 49885 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 49885

1-PLACE OF DEATH

City of BALTIMORE: (No. 211 E. Hamburg St. 24-33 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl Lindheimer

(a) Residence No. 211 E. Hamburg St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie D.

6-DATE OF BIRTH (month, day and year) Sept 1, 1861

7-AGE, 68 yrs. 1 mos. 6 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer). Mayer & Co.

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Mollie D. Lindheimer

(Address) 211 E. Hamburg St.

15-Filed 1929 1929 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 7, 1929.

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1929 to Oct 7 1929

last saw h alive on Oct 7 1929

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. H. Campbell M. D.

Oct 8 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Harmony Cem. Calvert County

DATE OF BURIAL. Oct 9 1929

20-UNDERTAKER. Fred. A. Fraunfelder & Son

ADDRESS 703 Hanover St.

...oc.—2-29-28—L. F. S.—500 Bks.

E 49836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-98 V

E 49836

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1804 Harford ST. 6-16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Kilian

(a) RESIDENCE NO. 1804 Harford Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kilian

6 DATE OF BIRTH (month, day, and year) 5/13/1853

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	76	4	23	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Bath. Stud Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Alexis Kilian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

Informant Mary Kilian

(Address) 1804 Harford Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 3 1929 to Dec 6 1929

that I last saw him alive on Dec 6 1929

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cardiac exhaustion

(duration) yrs mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Anderson M. D.

19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	12/9/29 19
20 UNDERTAKER Geo J Ruth	ADDRESS 1731 Harford Ave

...c.—2-29-28—L. F. S.—500 Blks.

E 49837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓ E 19837

1—PLACE OF DEATH Union Memorial Hospital — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33rd ST.) (WARD)

2—FULL NAME Mr. August C. Menzel

(a) RESIDENCE NO. Colgate, Md. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 1 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 24, 1909

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	20	1	12	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

(c) Name of employer: Minch - Landray

BIRTHPLACE (city or town) (State or country): Colgate, Maryland.

10 NAME OF FATHER: Herman C. Menzel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Anna Hillmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

Informant: Hospital Records
(Address)

File 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Oct 6, 1929

that I last saw him alive on Oct 6, 1929

and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Surgical Operation (Plastic on nose)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Lobar pneumonia, left 6

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Sept 30, 1929

Was there an autopsy? No.

What test confirmed diagnosis? X-Ray

(Signed) Francis T. T. Clark, M. D.

Oct 6. 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 9 1929
20 UNDERTAKER	ADDRESS
Geo C Miller & Son	2334 Jefferson

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19888

E 19888

CERTIFICATE OF DEATH

REGISTERED NO. 111-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST. (WARD)

2-FULL NAME Mrs. Albert Beard.

(a) RESIDENCE NO. 1738 N. Payson ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary H. Beard

DATE OF BIRTH (month, day, and year): 3-5-1863

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	66	7	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Adams Co Fairfield

10 NAME OF FATHER: Isaac Beard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Adams Co

12 MAIDEN NAME OF MOTHER: Ann Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant: Mary H. Beard

(Address): 1738 N Payson St

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Oct 8, 1929,

that I last saw h in alive on Oct 8, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary): Severe Secondary Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical & autopsy

(Signed) J. H. Mackenzie, M. D.

, 19 (Address) W. Balto Gen.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral H C Brannigan Son

DATE OF BURIAL: 10/11/1929

20 UNDERTAKER: H C Brannigan Son

ADDRESS 1130 Bolargo ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49889 Union Memorial Hosp 10-23 | 88-103 E 19889

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. [redacted] St., Ward)

2-FULL NAME Henry F. Hohlen

(a) RESIDENCE NO. 706 Arlington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27-1895

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
33 34		11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Post Office Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.A
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John M. Hohlen

11 BIRTHPLACE OF FATHER (city or town) Prince Georges Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Julia M. Ellinghaus

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant John M. Hohlen
(Address) 706 Arlington Ave

15 Filed ....., 19.... Registrar

1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract Skull auto he was driving collided with another throwing him out fracturing his skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Old York Rd

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) E. Frank M. D.

10 1929 (Address) 3909 W. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 9 1929
20 UNDERTAKER Robt J. Turnbull	ADDRESS 1443 N Broadway

E 49890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1179 E 49890

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Oliver Walk. Greenmount Ave WARD) REGISTERED No. C

If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Sutton Wilson

(Residence in Baltimore: No. 1023 N. Calvert St

(If under 1 day, ... hrs. ..... mins. If under 1 year, ... mos. ..... da. If 1 year or over, 75 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. September (Month) 29 (Day), 1854 (Year)

7-AGE. 75 yrs. 0 mos. 8 da. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Rec. Teller The Savings Bank of Balto

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. William Wilson

11-BIRTHPLACE OF FATHER (State or Country). Scotland

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (State or Country). Not Known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Bradwell

(Address) THE SAVINGS BANK OF BALTIMORE

15-

FILED 1929 C. HAMPSON JONES, M. D. Registrar.

Per ARH

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 7th (Month) (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro-Vascular-Renal Disease

(No Autopsy)

..... (Duration) ? yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) ..... M. D.
(Coroner)

10-8/29 ....., 191... (Address) 505 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cem	10-9, 1929

20-UNDERTAKER Henry W. Jenkins & Sons

ADDRESS Orchard & McCulloh Sts

Spec.—1-10-21—M&T—1500 Blks. Stepher Lonczyrski

E 49891 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49891

CERTIFICATE OF DEATH. 1127

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO. 35

CITY OF BALTIMORE: (No. ... ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Lunciuski

(a) RESIDENCE NO. 1406 Aisquith St ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 30 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Julia Lunciuski

6 DATE OF BIRTH (month, day, and year) Aug 25 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER James Lunciuski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Katherin Gumstoyski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Hospital Records

15 Filed 1929 C. HAMPSON JONES, M. D., Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6 1929

17 I HEREBY CERTIFY, That I attended deceased from 8/21 1929, to 10/6 1929, that I last saw h[illegible] alive on 10/6 1929, and that death occurred, on the date stated above, at 12 20 P. M.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Mitral stenosis + aortic insufficiency (duration) yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 9/6/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Robert Wells, M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Oct 9 1929

20 UNDERTAKER John M. Weber ADDRESS 401 S Chester

...c.—2-29-28—L. F. S.—500 Blks.

E 49892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 19892

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 Rosecroft Terrace ST. 20-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joel Henry Hayes

(a) RESIDENCE NO. 405 Rosecroft Terrace ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Almira V. Hayes

DATE OF BIRTH (month, day, and year) Sept. 30, 1856

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	-	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Maysville
(State or country) Kentucky

10 NAME OF FATHER John B. Hayes

11 BIRTHPLACE OF FATHER (city or town) Cecil County
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Roseanna Cole

13 BIRTHPLACE OF MOTHER (city or town) Cecil County
(State or country) Maryland

Informant Mr. Joel L. Hayes

(Address) Halethorpe, Md.

Filed 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 8, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1925, to Oct 8, 1925, that I last saw him alive on Oct 7, 1925 and that death occurred, on the date stated above, at 9.20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. From history mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Fred C Jones, M. D.

10/8. 1929 (Address) 2516 Pennsylvania Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Oct. 10, 1929

UNDERTAKER Wm H Cook

ADDRESS 1003 West Baltimore St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Abrams. 2360 Eutaw Place

E 49893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24 E 49893

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 E 20th ST., 9-46 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Riehl

(a) RESIDENCE NO. 734 E 20th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: James L Riehl

6 DATE OF BIRTH (month, day, and year): July 4, 1848

7 AGE: Years 81 | Months 3 | Days 3 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Cabot

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

Informant: Miss Lillian Riehl

(Address) 734 E 20th St

Filed 1929 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1929, to Oct 7th, 1929, that I last saw h[illegible] alive on Oct 7th, 1929, and that death occurred, on the date stated above, at 2 35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Michael A Abrams, M. D.

10. 8. 1929 (Address) 2360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 10/10 1929

20 UNDERTAKER: J. M. Cook

ADDRESS: 1217 St Paul St

...—2-29-28—L. F. S.—500 Bks.

E 49894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49894

1—PLACE OF DEATH Baltimore City Hospls REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. Balto Md ST., 9-18 WARD)

2—FULL NAME Raymond Zerbe

(a) RESIDENCE NO. 1725 Harford Ave ST., WARD
(Usual place of abode)

ngth of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

f married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Zerbe

ATE OF BIRTH (month, day, and year) 1876

GE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
53				

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

IRTHPLACE (city or town) State or country) Pennsylvania

0 NAME OF FATHER William Zerbe

1 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

2 MAIDEN NAME OF MOTHER Anne Gruver

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

Informant Records

(Address) Balto City Hospls

Fil 1929 , 19 H. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7-29

17

I HEREBY CERTIFY, That I attended deceased from 5-31-, 1929, to 10-7, 1929

that I last saw him alive on 10-7, 1929

and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane.

1 yr. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) H. Friedrich M. D.

(Address) Balto City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	10/9 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 E Pratt St

...—2-29-28—L. F. B.—500 Blks.

E 49895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49895

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD)

2—FULL NAME Mrs. Wm. H. Beale (Elsa) L.

(a) RESIDENCE NO. 2900 Evergreen Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. Beale

DATE OF BIRTH (month, day, and year): May 25 1882

AGE: Years 47 Months 5 Days 15 If LESS than 1 day, hrs. or min. 12 hrs 18 min

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Edmund L Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sara Morrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: Jessie Beale

(Address): 2900 Evergreen Ave

Filed 1929, 19 E. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Oct 7, 1929, that I last saw h[e] alive on Oct. 7 1929 and that death occurred, on the date stated above, at 6 03 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Cardiac Decompensation

Cardiac Hypertrophy

6 weeks (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Passive Congestion 6 weeks (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None Physical Findings

(Signed) Francis N. Glick, M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 10/9 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 E Pratt St

rec.—2-29-28—L. F. S.—500 Bks.

E 49484

E 49896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ✓ E 49896

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3-4 WARD)

2—FULL NAME Edward Rose

(a) RESIDENCE NO. 212 So. Spring St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Mu

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/3/1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. C.

10 NAME OF FATHER John Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. C.

12 MAIDEN NAME OF MOTHER Dollie Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. C.

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 9-1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-1-29

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1929, to Oct-1, 1929, that I last saw ~~him~~ alive on Oct-1, 1929 and that death occurred, on the date stated above, at 11 40 P m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis

Rheumatic Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 21 yrs. 0 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? -

(Signed) Alexander Preston, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

OCT 2 1929

PAT. SEC. F. W. S. & H.

...ec.—2-29-28—L. F. S.—500 Bks.

E 49397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 123 ✓ E 49397

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 4-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Anna Hohmann (Sr M Aburdata mot.)

(a) RESIDENCE NO. Notre Dame Convent ST., Balto WARD Roccapoles

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) October 19, 1874

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	54	11	18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer): Teacher

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Sebastian Hofmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Hospital records.

(Address)

Filed 6 1 30 '29 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7/1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to Oct 7, 1929

that I last saw her alive on Oct 7, 1929

and that death occurred, on the date stated above, at 2.40 P.M. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

(duration) 3-5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 10-7-29

Was there an autopsy? no

What test confirmed diagnosis? Clinical Test.

(Signed) M. Hohmann, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Natch Cliff Md.	Oct 10 1929
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St

pec.—2-29-28—L. F. S.—500 Bks.

E 49398

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 49398

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ITY OF BALTIMORE: (No. ST., 13-52 WARD)

2—FULL NAME Allen W. Underwood

(a) RESIDENCE NO. 703 Bennett Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ength of residence in city or town where death occurred 1/ yrs. mos. ds. How long in U. S., if foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Oct 31 1928.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	11	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore city
(State or country) Md.

10 NAME OF FATHER Claude W. Underwood.

11 BIRTHPLACE OF FATHER (city or town) Birmingham
(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Dora Light

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

Informant Claude W. Underwood.
(Address) 703 Bennett ave.

Filed 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 /29

17 I HEREBY CERTIFY, That I attended deceased from 8/28/29, 19..., to 10/8/29, 19..., that I last saw h[illegible] alive on 10/8/29, 19..., and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Alimentary Disturbance
Rickets

(duration) ... yrs. ... mos. 45 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? Primary disease contracted at home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Denner, M. D.

10/8/1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem't Finksburg Md	Oct. 17 1929
20 UNDERTAKER	ADDRESS
Walter Davis	3307 Fairmont

...ec.—2-29-28—L. F. S.—500 Blks.

E 49399 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 49399

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1826 N. Broadway ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J Roth

(a) RESIDENCE NO. 1826 N. Broadway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 5 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER John C Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie C Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Annie C Roth

(Address) 1826 N Broadway

Filed 10-10-1929 Roth Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1928 to Oct 7, 1929

that I last saw him alive on Oct 6, 1929

and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) Chas. E. Keyser M. D.

10/11/29 (Address) 408 Dat Bank Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 10th 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

Spec.—8-16-29—L. F. S.—100 Bks.

E 49900 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 E 49900

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 833 N. Hay ST. 10-14 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rivera Horwitch

(a) RESIDENCE NO. 833 N. Hay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Abraham Horwitch

DATE OF BIRTH (month, day, and year) December.

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	60			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Isaac Hopkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Freida —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Jack Levis

(Address) 1439 E Balto St

Filed Oct 10 1929 C. HAMILTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 8, 1929, that I last saw h alive on Oct 8 1929 and that death occurred, on the date stated above, at 3 30 A m.

The CAUSE OF DEATH* was as follows:

Ch Myocarditis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? N

Did an operation precede death? N Date of —

Was there an autopsy? none

What test confirmed diagnosis? Physical

(Signed) A H Hornstein M. D.

10/9 1929 (Address) 733 Bisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Rosedale

DATE OF BURIAL 10/9 1929

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Balto St

...ec.—2-29-28—L. F. S.—500 Blks.

E 49901 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-002 E 49901

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Smith

(a) RESIDENCE NO. 1200 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Aug 5th 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	2	3	
	80	"	"	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Joseph Keahl

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Catherine Boots

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Little Sisters of the Poor

(Address) 1200 Valley St

Filed 1929 G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/8/29.

17 I HEREBY CERTIFY, That I attended deceased from 10/6, 1928, to 10/8, 1929, that I last saw her alive on 10/7, 1929, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Carroll, M. D.

10/8/29 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 10 1929
20 UNDERTAKER	ADDRESS
Rila Weedefeld	4 Lexington

...c.—2-29-28—L. F. S.—500 Blks.

E 49902 HEALTH DEPARTMENT—CITY OF BALTIMORE VE 49902

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 10-14 90

ITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse Cook

(a) RESIDENCE NO. 713 Eden ST., WARD
(Usual place of abode)

ngth of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

ATE OF BIRTH (month, day, and year) Unknown

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

CCUPATION OF DECEASED

a) Trade, profession or particular kind of work Laborer

b) General nature of industry, business, or establishment in which employed (or employer)

c) Name of employer

RTHPLACE (city or town) State or country) Maryland

0 NAME OF FATHER John Cook

1 BIRTHPLACE OF FATHER (city or town) (State or country) ? Unknown

2 MAIDEN NAME OF MOTHER Charity Plumer

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Records of

(Address) Balto. City Hospitals

Filed [illegible] 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1928, to Oct. 7, 1929, that I last saw him alive on Oct. 7, 1929 and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Facult

over
(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

over
(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lab. PC Lab

(Signed) Marvin M. McClain M. D.

10-8, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	10/9 1929
20 UNDERTAKER	ADDRESS
Saml. Shawley	5784 Beddle

...ec.—2-29-28—L. F. S.—500 Blks.

E 49903

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49903

CERTIFICATE OF DEATH

100.00

1—PLACE OF DEATH — REGISTERED NO.

...ITY OF BALTIMORE: (No. Baltimore City Hosp ST. 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susie Lee

(a) RESIDENCE NO. 232 N. Broad ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX: ...em

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Otto Lee

...ATE OF BIRTH (month, day, and year): Unknown

...GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	39			

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

...RTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Robert Field

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Murdock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

Informant: Hospital Record

(Address):

Filed ...19 29 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/6/29

17 I HEREBY CERTIFY, That I attended deceased from 8/31, 1929, to 10/6, 1929

that I last saw h...r alive on 10/6, 1929

and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Recto vaginal fistula

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. A. Crumpler, M. D.

10/6. 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct 9th 1929
20 UNDERTAKER: Mrs. R. G. Elliott	ADDRESS: 1725 Archbald

...ec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 49904

E 49904

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

ITY OF BALTIMORE: (No. Balto. city Hosp. ST. 12-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Wright

(a) RESIDENCE NO. 1230 W 21-50 ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

ngth of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

ATE OF BIRTH (month, day, and year) [illegible] 1865

GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	64			

CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

IRTHPLACE (city or town) State or country) Maryland

0 NAME OF FATHER Peter Duncan

1 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

2 MAIDEN NAME OF MOTHER Mayard ?

3 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Record
(Address)

Filed ... 19 1929 HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6/29

17 I HEREBY CERTIFY, That I attended deceased from 9/19, 1929, to 10/6, 1929

that I last saw h-r alive on 10/6, 1929

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic infectious arthritis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin, M. D.

10/7. 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct 9th 1929
20 UNDERTAKER Wm. R. G. Elliott	ADDRESS 1725 Eastlander

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49905

CERTIFICATE OF DEATH

100-001 E 49905

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2231 Penrose ave St. 70-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Jane Auer

(a) RESIDENCE NO. 2231 Penrose ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) 2-29-28

AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	1	7	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Balto. Md

10 NAME OF FATHER: Earl E. Auer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Lizzetta Spelling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

Informant: Earl E. Auer

(Address): 2231 Penrose ave

Filed ..., 19 ... Registrar ...

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 7. 29

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1929, to October 7, 1929, that I last saw her alive on October 7, 1929 and that death occurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Bronchial pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical

What test confirmed diagnosis? Mary A. Hale

(Signed) ..., M. D.

10-8, 1929 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 9 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Son	1901 Eutaw

Spec.—1-10-21—M&T—1500 Blks.

E 49906 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 49906

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Rosenberg

(a) RESIDENCE NO. 5809 Clover Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Jewish	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Samuel Rosenberg

6 DATE OF BIRTH (month, day, and year) July 7 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Isaac Baum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Baum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Samuel Rosenberg (Address) 5809 Clover Road

Filed Oct 9 1929 CHAMPION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1929, to Oct. 8, 1929, that I last saw her alive on Oct. 8, 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Lung tumor — Carcinoma?

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Lung Tumor Carcinomatosis

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) B J Kahn, M. D.

Oct 8. 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	Oct 10, 29
20 UNDERTAKER	ADDRESS
Hof Levinson & Bro	2 Balto st

Spec.—1-10-21—M&T—1500 Blks.

E 49907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

* 179 E 49907

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 W Barre ST. 22-30 WARD)

2-FULL NAME Mary Johnson

(a) RESIDENCE NO. 540 W Barre ST., WARD B. C.
(Usual place of abode)
Length of residence in city or town where death occurred — yrs. — mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Col
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Johnson

6 DATE OF BIRTH (month, day, and year): Jan - 2 - 1845

7 AGE: Years 37 | Months 9 | Days 4 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wood Land - N. Carolina

PARENTS

10 NAME OF FATHER: Lee Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Alice Wright
(Address) 540 W Barre

15 Filed 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept - 18, 1929, to Oct 6, 1929, that I last saw h[illegible] alive on Oct 6, 1929, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary): Chr. Nephritis

(duration) — yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine albumin +

(Signed) Dan Trunken, M. D.

(Address) 1122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem

DATE OF BURIAL: Oct. 9 1929

20 UNDERTAKER: C. W. Brown & Son

ADDRESS: 108 W. Monument

...ec.—2-29-28—L. F. S.—500 Blks.

E 49908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 49908

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 521 S. Lakewood Ave ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wicenty Lewandowski

(a) RESIDENCE NO. 1504 Bank St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) June 29 1865

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	64	3	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Wicenty Lewandowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Wielepska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

Informant John Lewandowski

(Address) 2715 Jefferson St

Filed ... 1929 C. H. JOHNSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7. 29.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 19 29 to Oct 7 19 29

that I last saw him alive on Oct 7 19 29

and that death occurred, on the date stated above, at 3300 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William R. Daniels M. D.

19 29 (Address) 502 E. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Oct. 10	1929 19

20 UNDERTAKER E. W. Ozazewski 1950 Eastern ADDRESS

Spec—12-23-21—E.B.R.S.—400 Eks.

E 49909 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 E 49909

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 925 W. Franklin St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Theresa Gallagher

(a) Residence No. 925 W. Franklin St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 0 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Gallagher

6-DATE OF BIRTH (month, day and year) Sept 22, 1858

7-AGE. 71 yrs. 0 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... nurse (Practical)

(b) General nature of industry, business, or establishment in which employed (or employer)..... retired

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto., Md (State or Country).

PARENTS

10-NAME OF FATHER. Anton Gründer

11-BIRTHPLACE OF FATHER (city or town)..... Germany (State or Country).

12-MAIDEN NAME OF MOTHER. Mary Bosse

13-BIRTHPLACE OF MOTHER (city or town)..... Germany (State or Country).

14-(Informant) Mrs Marie Clark

(Address) 925 W. Franklin St.

15-Filed 9 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 8, 1929

17- I HEREBY CERTIFY, That I attended deceased from April 22 1929 to Oct 8 1929

that I last saw her alive on Oct 8, 1929

and that death occurred, on the date stated above, at 8:29 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis.—

cerebral hemorrhage

(Duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac ~~renal~~ failure

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) George A. Krupp M. D

19 (Address) 3630 Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral	10-11-1929
20-UNDERTAKER. Browning Bros	ADDRESS 1136 Baltimore St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49910

1-PLACE OF DEATH

CERTIFICATE OF DEATH

E 49910

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 3304 Gilman Terrace St., 13 Ward)

2-FULL NAME Edward Scheurer

(a) RESIDENCE NO. 3304 Gilman Terrace St., 13 Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Justine Scheurer

6 DATE OF BIRTH (month, day, and year) July 15, 1842

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	87	2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 16 years
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Cincinnati, Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Leonora M. Rei
(Address) 3304 Gilman Terrace

15 Filed ..., 19.. C. HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jobular Pneumonia
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10-9, 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middletown, Ohio	Oct. 9, 29

20 UNDERTAKER Horace F. Burgee ADDRESS 731 Fulton Ave

Spec.—1-10-21—M&T—1500 Blks.

E 49911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **U.S. Marine Hospital, Baltimore, Md.**

CITY OF BALTIMORE: (No.) ST., 3-4 (WARD)

REGISTERED NO. E 49911

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME **Gus W. Keyser**

(a) RESIDENCE NO. **The Anchorage, Baltimore, Md.** ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred **30** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	**white**	**single**

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) **April 28, 1873**

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	**5**	**7**	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Seaman**

(b) General nature of industry, business, or establishment in which employed (or employer) **Seaman**

(c) Name of employer **SS Betty Weems**

9 BIRTHPLACE (city or town) (State or country) **Virginia**

PARENTS

10 NAME OF FATHER **Charles Keyser**

11 BIRTHPLACE OF FATHER (city or town) (State or country) **unknown**

12 MAIDEN NAME OF MOTHER **Lillie Dodson**

13 BIRTHPLACE OF MOTHER (city or town) (State or country) **Northumberland Co., Va.**

14 Informant **Records, U.S. Marine Hospital**
(Address) **Baltimore, Md.**

15 File **1929** By **Ellen** Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **Oct. 5** 19 **29**

17

I HEREBY CERTIFY, That I attended deceased from **October 2** 19 **29**, to **October 5** 19 **29**,

that I last saw h**im** alive on **October 5** 19 **29**,

and that death occurred, on the date stated above, at **1:15** A m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction, adhesions

(duration) yrs. mos **5** ds.

CONTRIBUTORY (Secondary) **Albuminuria**

(duration) **unknown** yrs. mos. ds.

18 Where was disease contracted if not at place of death? **Aboard ship**

Did an operation precede death? **yes** Date of **Oct. 3**

Was there an autopsy? **No**

What test confirmed diagnosis? **Operation**

(Signed) Bradley D Hodgkins M. D.

10/5 19 29 (Address) **U.S. Marine Hospital, Balto.**

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL **Monaskon, Virginia** — DATE OF BURIAL **Oct. 9, 1929**

20 UNDERTAKER **E. LeRoy Stiffler, Inc** — ADDRESS **125 E. Nath ave**

Spec.—1-12-23—M&T—500 Bks.

E 49912 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (Ward) 25

REGISTERED NO. 11-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Mellon

(a) RESIDENCE No. 124 Pearl St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

DATE OF BIRTH (month, day, and year) ? 1895

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) S. C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Catherine Mellon

(Address) 124 Pearl St

Filed 1929 . 19 HAMPSON JONES, M. D. Registrar NKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8- 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-28- , 1929, to 10-8- , 1929, that I last saw him alive on 10-8- , 1929, and that death occurred, on the date stated above, at 10.05 a m.

The CAUSE OF DEATH was as follows:

Gastric Ulcer

Peritonitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/30/29

Was there an autopsy? Yes

What test confirmed diagnosis? Post Mortem

(Signed) L. L. Jackson M. D.

10/8/1929 (Address) Prov. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	10/10/1929
20 UNDERTAKER	ADDRESS
Wm. Geo. H. Holland	1618 Druid Hill

Spec.—1-12-23—M&T—500 Blks.

E 49913 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 49913

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital 17-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fraggie Johnson

(a) RESIDENCE No. 653 Pierce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	infant

a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

DATE OF BIRTH (month, day, and year) Aug. 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balt. Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mother or Admission to hosp.

(Address)

FILED 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929. to Oct 8, 1929.

that I last saw him alive on Oct 8, 1929,

and that death occurred, on the date stated above, at 6.05 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro - Intestinal Toxicosis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Geo McDonald M. D.

, 19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 10/9/1929

20 UNDERTAKER Geo. H. Holland — ADDRESS [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

E 49914

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49914

CERTIFICATE OF DEATH.

161-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1038 Pennsylvania Av. 14-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Baby boy Harley

(a) Residence No..... St., ... Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, ✓ Single Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 3, 1929

7-AGE, ... yrs. ..... mos. 1½ ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edward Harley

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Columbia S.C.

12-MAIDEN NAME OF MOTHER, Novell Ballard

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore Md.

14-

(Informant).....

(Address).....

15-

Filed ..... 192.....

C. HAMPSON JONES, M.D.

Registrar.

1929 Oct 31

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct 5, 1929

17- I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929 to Oct 5, 1929 that I last saw him alive on Oct 5, 1929 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity - 35 weeks

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paternal Lues

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis? Wassermann

(Signed) Louis B. Mayer Lues M. D.

10/7/29 (Address) Mercy Hosp. Bal

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND

DATE OF BURIAL. ..... 19....

20-UNDERTAKER. Commissioner

ADDRESS

OCT 8 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 49915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 49915

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 27-48 St. (WARD)

2—FULL NAME Baby Keating

(a) RESIDENCE NO. 304 Evesham Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) 10-5-29

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			1/2 hr	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER John N. Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily C. Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant

(Address)

Filed OCT 9 1929 C. HAMPSON JONES, M. D. BY Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5-29

17 I HEREBY CERTIFY, That I attended deceased from 10-5, 1929, to 10-5 1929.

that I last saw him alive on 10-5, 1929

and that death occurred, on the date stated above, at 7 10 A m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

10/5, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL	19
UNDERTAKER Commissioner Health	ADDRESS OCT 9 - 1929

Cor.—12-9-25—A Co.—200 Bks.

E 49916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1007

187 E 49916

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 10-15 Ward)

2-FULL NAME James L. Vereker Sr.

(a) RESIDENCE NO. 1116 Forest St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	60 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Sweet Air

(c) Name of employer Balto. Co. Md.

9 BIRTHPLACE (city or town).....

(State or country) Ireland

PARENTS

10 NAME OF FATHER Richard Vereker

11 BIRTHPLACE OF FATHER (city or town).....

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country) Ireland

14 Informant Son Joseph Vereker

(Address) 1116 Forest St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

6130

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Gas Gangrene of Left Lower Knee Caused by Injury to medial malleolus of Left Ankle Bone Grinding (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Embolism Palmer Edenal (duration) ..... yrs. ..... mos. ..... ds.

Oct. 9 (Dated) ..... M. T. Culley (Coroner) M. D.

, 19 29 (Address) 1639 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's Cemetery Long Green Md. Date of Burial Oct. 11, 1929

20 UNDERTAKER Elmer W. Conklin ADDRESS 924 E Eager St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49917 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49917

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital St., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Eugene F. Chamberlain

(a) RESIDENCE NO. 212 N. Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred - yrs. 6 mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lee Barnette

DATE OF BIRTH (month, day, and year) Sept. 28, 1856

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	0	10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U. S. Commissioner

(b) General nature of industry, business, or establishment in which employed (or employer) Navigation

(c) Name of employer

BIRTHPLACE (city or town) Albany

(State or country) New York

10 NAME OF FATHER Frank Chamberlain

11 BIRTHPLACE OF FATHER (city or town) Albany

(State or country) New York

12 MAIDEN NAME OF MOTHER Celia D. Tyler

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

Informant Mrs. Leo H. Fallon

(Address) 212 N. Payson Street

Filed 1929, 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 26, 1929, to Oct 8, 1929

that I last saw h[illegible] alive on 10/8, 1929

and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Theo. E. Stacy Jr. M. D.

. 19 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 10/11 1929

29 UNDERTAKER: Henry A. Mears and Son

ADDRESS: 405 N. Calvert

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49918

CERTIFICATE OF DEATH.

E 49918

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3907 Goodbine Ave ST. 28-64 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eliza Bucklee

(a) RESIDENCE NO. 3907 Goodbine Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of or) WIFE of Thomas H. Bucklee

6 DATE OF BIRTH (month, day, and year) Dec 18/1856

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bristol
(State or country) England

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant William F Bucklee
(Address) 157 Halsted St East Orange N.J.

15 Filed 1929 (19) G HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1929

17

I HEREBY CERTIFY, That I attended deceased from October 2, 1929, to October 8, 1929, that I last saw her alive on October 8, 1929, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry T. Coltenberg, M. D.

10/9, 1929 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Oct 10 1929

20 UNDERTAKER Harry H Annacot — ADDRESS 4204 Ridgewood Ave

...—2-29-28—L. F. S.—500 Blks.

E 49919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 49919

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 Covington St ST. 24-3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Mauzy

(a) RESIDENCE NO. 1533 Covington st ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of Champ Mauzy

DATE OF BIRTH (month, day, and year) Mar 1 1859

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	7	8	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Frederick Md.

10 NAME OF FATHER Edward Hilleary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Keifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Mrs. Fisher

(Address) 1533 Covington St

Filed 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-29

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to Oct 9, 1929.

that I last saw her alive on Oct 9 1929

and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with Hypertension

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 1 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Streett M. D.

10/9. 1929 (Address) 1445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem Frederick Md. DATE OF BURIAL 10/11 1929

20 UNDERTAKER J. Tew McCully ADDRESS 130 E. Fort

Spec.—1-10-21—M&T—1500 Bks.

E 49920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 49920

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 1-3 WARD)

2-FULL NAME Felix Grzymala

(a) RESIDENCE No. 2306 Boston St ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Grzymala

6 DATE OF BIRTH (month, day, and year) May 22-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate merchant

(b) General nature of industry, business, or establishment in which employed (or employer) O'wn

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Adolfil Grzymala

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Karwowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Grzymala (Address) 2306 Boston St

15 Filed 1929 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4 . 1929 . to Oct. 8 . 1929.

that I last saw him alive on Oct. 8 . 1929

and that death occurred, on the date stated above, at 7:35 A m.

The CAUSE OF DEATH* was as follows

Empyema, rt. side

Cancer, stomach

10 days (empyema)

2 yrs. (Ca) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma - stomach

(duration) 2 ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation - Autopsy

(Signed) BJ Cohen M. D.

(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 10 12 1929

20 UNDERTAKER John M. Weber

ADDRESS 401 N. Charles

Spec.—1-10-21—M&T—1500 Blks.

E 49921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 49921

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 S Chapel ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Tuliszewski

(a) RESIDENCE NO. 527 S Chapel St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0+0

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Daughter

(Address) 527 S Chalel

15 Filed 1929, 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1929

17 I HEREBY CERTIFY, That I attended deceased from October 2, 1929, to Oct. 7, 1929, that I last saw him alive on Oct. 7, 1929, and that death occurred, on the date stated above, at 5 00 P.M.

The CAUSE OF DEATH* was as follows: Thyocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

1/9, 19 3 (Address) 7549 Easton Rd,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL 11 19 29

20 UNDERTAKER John N Weber

ADDRESS Chester Pa

...ec.—2-29-28—L. F. S.—500 Bks.

E 49922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 49922

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

...ITY OF BALTIMORE: (No. ..... ST., 8-16 WARD)

2—FULL NAME Henry Muller or Miller

(a) RESIDENCE NO. 2435 E. Federal ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

...ngth of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

...EX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
...ale	White	~~Single~~ Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

...ATE OF BIRTH (month, day, and year) ~~Unknown~~ 1849

...GE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

...CCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

...IRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Charles Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margretta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Records of Baltimore City Hospitals

(Address)

...Filed 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1929, to Oct. 7, 1929, that I last saw him alive on Oct. 7, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Parenchymatous

(duration) over 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension

(duration) over 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C.C.

(Signed) Harris M. McLean, M. D.

10-8, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cem Oct 10	1929
20 UNDERTAKER	**ADDRESS**
John C. Miller	2435 E Oliver

Isaac Elkon

E 49923

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49923

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 12449

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 1201 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Elkon

(a) RESIDENCE NO. 807 4th St SE Wash DC ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

If married, widowed or divorced HUSBAND of (or) WIFE of Edna Elkon

DATE OF BIRTH (month, day, and year) Dec 18, 1891

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
39	38	9 10	17 21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Jacob Elkon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Elkon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Edna Elkon

(Address) Wash D.C.

Filed ..., 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 4th, 1929, to Oct 9th, 1929, that I last saw him alive on Oct 9th, 1929 and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Post Operative Shock and Pneumonia. Pulmonary Edema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Thyroid

Diabetes (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 7, 1929

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C Hampson M. D.

10/9, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C.

DATE OF BURIAL 10/9 1929

20 UNDERTAKER Jack Levin 1439 E Balto St

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49924

CERTIFICATE OF DEATH.

111-001

E 49924

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) Provident Hospital WARD 17-26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Simpson

(a) RESIDENCE NO. 411 N Fremont Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie Simpson

DATE OF BIRTH (month, day, and year): 9

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: C laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

Informant (Address): Wife or Advising

Filed 1929 .19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 8 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 5 .1929. to Oct 8 .1929.

that I last saw h/M alive on Oct 8 .1929

and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

From Ruptured Gastric Ulcer

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Gastric Ulcer.

(duration)? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) R. L. Jackson M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 10/12/29

20 UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS: 1660 Druid

gest.—2-29-28—L. F. S.—500 Blks.

E 49925

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49925

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 12-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr Hugh Chatham

(a) RESIDENCE NO. Winston Salem N C ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

DATE OF BIRTH (month, day, and year) June 9, 1864

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	4	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blanket Mgf.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Elkin N. C.

10 NAME OF FATHER Alexander Chatham

11 BIRTHPLACE OF FATHER (city or town) Walkersborough (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Gwyn

13 BIRTHPLACE OF MOTHER (city or town) Elkin (State or country) N. C.

Informant Hospital Record

(Address)

Filed OCT 10 1929 C. HAMPSON JONES, M. D. Registrar

Pat. GKG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 10, 1929, that I last saw him alive on Oct 10, 1929, and that death occurred, on the date stated above, at 2 10 A.m.

The CAUSE OF DEATH* was as follows:

Post operative Ileus
Pulmonary Edema

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Emphysema gall bladder

(duration) 5 yrs. mos. da.

18 Where was disease contracted if not at place of death? N. C.

Did an operation precede death? yes Date of Oct 5th

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C C Thompson, M. D.

10/10. 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winston-Salem N. C.	Oct 10 1929
20 UNDERTAKER Henry Benbow & Son	ADDRESS Oakland Mt Gilead

Spec- 12-23-21—E.B.R.S.—400 Lks.

E 49926 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49926

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

City of BALTIMORE: (No. 1306 W. Lanvale St. 16-23 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet E. Green

(a) Residence No. 1306 W. Lanvale St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, ~~Married~~ Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Edw. Green

6-DATE OF BIRTH (month, day and year) Aug 2 1869

7-AGE. 60 yrs. 2 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Solomon Ennis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Sarah A. Stewart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Emmaline Wilson

(Address) 1306 W. Lanvale

15- Filed OCT 10 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 7/29

17- I HEREBY CERTIFY, That I attended deceased from July 22cc 1929 to October 7th 1929 that I last saw her alive on October 1st cc 1929 and that death occurred, on the date stated above, at 7-10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and Adnexa

(Duration One yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Bramwell Lang M. D.

, 19 (Address) 2937 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn

DATE OF BURIAL. Oct 10, 1929

20-UNDERTAKER. John H. Tradin

ADDRESS 1027 Druid Hill

Spec.—2-29-28—L. F. S.—500 Bks.

E 49927 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH

129 E 19927

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Hough Hosp ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Primrose

(a) RESIDENCE NO. 1300 N. Luzerne St. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Primrose

DATE OF BIRTH (month, day, and year) Dec 15, 1871

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	9	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Special Officer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto Tube Co

BIRTHPLACE (city or town) (State or country): Boston Mass

10 NAME OF FATHER: Samuel H Primrose

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Josephine Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: Viola Primrose

(Address) 1300 N Luzerne

Filed OCT 10 1929, 19 C. HERBERT JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-9-29

17 I HEREBY CERTIFY, That I attended deceased from 10-6, 1929, to 10-9, 1929, that I last saw him alive on 10-9, 1929, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulm. Conjestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M H Lundrey, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 10/11 1929

20 UNDERTAKER: H. Cook

ADDRESS: 1217 E Pratt St

Spec.—2-29-28—L. F. S.—500 Blks.

E 19928

229872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 19928

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carl Tolson

(a) RESIDENCE NO. Hereneville Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	child

If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

DATE OF BIRTH (month, day, and year) 1/30/19

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	10	8	9	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Wilmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Myrtle Sommers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed ... 19... C. HUDSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929 to Oct 9, 1929

that I last saw him alive on Oct 9, 1929

and that death occurred, on the date stated above, at 1 40 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, cerebellar, glioma (malignant)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hereneville Md

Did an operation precede death? Yes Date of 10/8/29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation + autopsy

(Signed) Harvey E. Gardner Jr., M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hereneville, Md

DATE OF BURIAL 10/10 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

E 49929 HEALTH DEPARTMENT—CITY OF BALTIMORE 10-08 E 49929

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 Pierce ST. 17-26 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sueno Webster

(a) RESIDENCE NO. 711 Pierce ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Sorenia Webster

DATE OF BIRTH (month, day, and year) — 1867

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	—	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 045

(b) General nature of industry, business, or establishment in which employed (or employer) Ironing + Loading

(c) Name of employer J. Obers Fertilizer Wks

BIRTHPLACE (city or town) Lancaster Co.,
(State or country) Virginia

10 NAME OF FATHER Carter Webster

11 BIRTHPLACE OF FATHER (city or town) Lancaster Co.
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) Lancaster Co.
(State or country) Virginia

Informant Sorenia Webster
(Address) 711 Pierce

Filed 10 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/29

17

I HEREBY CERTIFY, That I attended deceased from 10/7, 1929 to 10/9, 1929, that I last saw h alive on 10/8, 1929 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dan Ramchen, M. D.

10/9, 1929 (Address) 1111 Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fort Lincoln Cem	10-10 1929
19 UNDERTAKER	ADDRESS 916
Dennis Talbot	Park

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19930 | CERTIFICATE OF DEATH | E 19930

1—PLACE OF DEATH — REGISTERED NO. 7408

CITY OF BALTIMORE: (No. University Hospital ST. 27-48 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Scott S. Roberts

(a) RESIDENCE NO. 307 E. Lake Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of ~~WIFE~~ Olivia Roberts

DATE OF BIRTH (month, day, and year)

AGE: 54 Years | Months | Days | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Hardware store

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Jos F. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Anna A Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

Informant: Olivia S. Roberts

(Address) 307 Lake Ave

Filed [illegible] 19 29 Registered by [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 28. 1929 to Oct 9. 1929

that I last saw h[illegible] alive on Oct 8 . 1929

and that death occurred, on the date stated above, at 8 4 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. F. Varney M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forrest Cemetery — DATE OF BURIAL: Oct 11 19 29

20 UNDERTAKER: [illegible] — ADDRESS [illegible]

Bjsec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49931

74-004

E 49931

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2804 St Paul ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abigail Dunn Griesemer

(a) RESIDENCE NO. 2804 St Paul ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Red Henry A Griesemer

DATE OF BIRTH (month, day, and year) Oct 11 1854

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) N. Y.

10 NAME OF FATHER Robert D Grier

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Mrs H A Griesemer

(Address) 5218 Springlake Way

Filed Oct 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, to Oct 7th, 1929, that I last saw h alive on Oct 7th, 1929, and that death occurred, on the date stated above, at 1:45 P.m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis (with hypertension)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert L. Mitchell, M. D.

10/9, 1929 (Address) 2112 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Oct 10 1929
20 UNDERTAKER John O Mitchell Son	ADDRESS 1900 Eutaw Place

Cor.—10-10-29—A Co.—100 Blks.

E 49932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 49932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 16-22 Ward)

2-FULL NAME Clarence Berry.

(a) RESIDENCE NO. 1021 N. Fulton St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha.

6 DATE OF BIRTH (month, day and year) 1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	32-			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm Garey.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Frank B. Lawson.
(Address) 629 N. Lee

15 Filed 10 1929 (C.) BROOKE JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Fractured Skull

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Thrown back on head

(duration) yrs. mos. 1 ds.

18 Where was disease contracted, if not at place of death? 1021 N. Fulton

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. D.

(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-10-29
20 UNDERTAKER	ADDRESS
Wm H Eade	916 Mt Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 49933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 49933

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 21-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Hartlove

(a) RESIDENCE NO. 1131 Cleveland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

DATE OF BIRTH (month, day, and year) March 22, 1928

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	16	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Clarence Hartlove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Thelma Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant Clarence Hartlove

(Address) 1131 Cleveland St.

Filed OCT 10 1929, 19 C. HUMPTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1929, to Oct 8, 1929, that I last saw him alive on Oct 8, 1929, and that death occurred, on the date stated above, at 10 25 p.m.

The CAUSE OF DEATH* was as follows:

Simple Encephalitis

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. 1 mos. 1 ds.

(duration) 0 yrs. 0 mos. 10 ds.

18 Where was disease contracted if not at place of death? 1131 Cleveland St

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & X ray

(Signed) Addison Craft Jr., M. D.

10-9, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 10-11 1929

UNDERTAKER Bernard C. Harlow

ADDRESS 1000 S. Paca St

Spec.—8-16-29—L. F. S.—100 Blks.

E 49934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49934

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5010 Belair Rd ST. 27-41 WARD) REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M Smith

(a) RESIDENCE NO. 5010 Belair ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John J Smith

DATE OF BIRTH (month, day, and year) Aug 29

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	1	11 10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ay home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Chas Lehman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant John J Smith

(Address) 5010 Belair Rd

Filed OCT 10 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9 29

17

I HEREBY CERTIFY, That I attended deceased from 10-1 29, to 10-9 29, that I last saw h[illegible] alive on 10-8 29, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH was as follows:*

Mitral Regurgitation

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) 9 yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M.D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Oct 11 1929

20 UNDERTAKER John Ulbert

ADDRESS 2008 Orleans

Spec.—2-29-28—L. F. S.—500 Bks.

E 49935 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 49935

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST. 15-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nora Elizabeth Ward.

(a) RESIDENCE NO. 2010 Ridgehill ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Married

DATE OF BIRTH (month, day, and year) Dec 10 1893

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	10	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Frank B Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Narbon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Frank B. Ward

(Address) 2010 Ridgewood Ave

Filed OCT 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929. to Oct. 10, 1929.

that I last saw h.r alive on Oct 10, 1929

and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Cardio vascular renal disease

(duration) ? yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) 2 yrs. 2 mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Rudolph L. Schork, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Balto Md	Oct 12 1929
20 UNDERTAKER	ADDRESS
Isaiah Ryfer	1600 W North Ave

Cor.—10-10-29—A Co.—100 Bks.

E 49936

Michael Hepner

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 49936

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 604 S. Broadway St. 2-4 Ward)

2-FULL NAME Michael Hepner

(a) RESIDENCE NO. 604 S. Broadway Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annirla Hepner

6 DATE OF BIRTH (month, day and year) Sept 6 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	1	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Store-keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Martin Hepner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Gramsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Annirla Hepner
(Address) 604 S. Broadway

Filed OCT 1 0 1929

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Talley M. D.

10/9/ 19 29. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Oct 12 1929
20 UNDERTAKER	ADDRESS
William Walbrook	1615 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 49937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 49937

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Stewart

(a) RESIDENCE NO. 112 Colvin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Emory Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Records of

(Address) Baltimore City Hospitals

Filed OCT 10 1929 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1928, to Oct. 7, 1929.

That I last saw him alive on Oct. 7, 1929

and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Syphilis

about 7? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypocardiitis, chronic & acute

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wass. & Clinical

(Signed) Marvin M. McLean, M. D.

10-8, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Oct 10, 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Wolfe St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49938

CERTIFICATE OF DEATH

89 E 49938

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 922 W. Lexington St. 18-7b Ward)

2-FULL NAME Bertie Washington

(a) RESIDENCE NO. 922 W. Lexington St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30-1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Washington

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Ida Bell Johnson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Miss Laura Washington
(Address) 1329 Filmore St

15 Filed OCT 10 1929 19.. C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) ..... yrs. 2d mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zellers M. D.

10-7. 19 29. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL Oct 10, 1929

20 UNDERTAKER M. D. Mrs Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—2-29-28—L. F. S.—500 Blks.

E 19939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

E 19939

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2609 Shirley Ave ST. 5-58 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lelara Frances Owens

(a) RESIDENCE NO. 2609 Shirley Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) April 17 1869

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer): Real Estate

(c) Name of employer: Sugan & Kephart

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Philip Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Kryphes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

Informant: Mrs Mary E Harris

(Address) 2609 Shirley Ave

Filed OCT 10 1929 C. HAMPSON JONES, Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 3 1929, to Oct 8 1929, that I last saw her alive on Oct 6 1929 and that death occurred, on the date stated above, at 4 a; m.

THE CAUSE OF DEATH* was as follows:

Carcinoma of left breast
Extension to left pleura + lung
metastases to axilla etc.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James L. Ashhurst, M. D.

10-8-29 (Address) 4012 Cane Hyde Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Oct 10 1929
20 UNDERTAKER	ADDRESS
J. Wickes Sons	Norwood

Spec'l—2-29-28—L. F. S.—500 Blks.

E 49940

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49940

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Smith

(a) RESIDENCE NO. 927 Druid Hill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Record

(Address)

Filed OCT 10 1929 C. HAMPSON JONES,

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5/29

17 I HEREBY CERTIFY, That I attended deceased from 9/20/28 to 10/5/29

that I last saw h-- alive on 10/5/29

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Chronic infectious arthritis

(duration) Unknown da.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. O. Rumpkin, M. D.

10/6/1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Oct 10 1929
20 UNDERTAKER John J. Fahey Sons	ADDRESS 1318 Light St

Spec.—1-12-23—M&T—500 Blks.

E 49941

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49941

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No. 1000 Caton Ave ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Schmaltz

(a) RESIDENCE NO. 1425 Edmondson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER John H. Schmaltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) French Unknown.

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

Informant Jenkins Memorial Hosp

(Address) 1000 Caton Ave

Filed Oct 9 1929 C. HAMPSON JONES, M.D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1928, to Oct. 9, 1929, that I last saw him alive on Oct. 9, 1929, and that death occurred, on the date stated above, at 7-45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL 10-11-29

20 UNDERTAKER Martin Fahey & Sons.

ADDRESS 1827 W North Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49942

CERTIFICATE OF DEATH.

90 E 19942

1-PLACE OF DEATH

City of BALTIMORE: (a) Md. Penitentiary St. 10-15 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Lang

(a) RESIDENCE NO. 954 Forest St. Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: 40 Years | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Pen
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Unk

14 Informant: Nat Lee Reeds.
(Address) 954 Forster St.

15 Filed 10-16-1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Valv dis Heard

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

Oct 10 (Signed) [illegible] M. D.
, 19 29 (Address) (Coroner) 1639 Bruns

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg Va Oct 10 1929

20 UNDERTAKER: Samuel L Barclay ADDRESS: Mt Bible

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49943

CERTIFICATE OF DEATH

90

E 49943

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1224 S. Clinton ST. 16-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marion S. Hansen

(a) RESIDENCE NO. 1224 S. Clinton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of T. Gustav Hansen

DATE OF BIRTH (month, day, and year) ? 1867

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) London, Eng

10 NAME OF FATHER George Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

Informant Mary C. Ferguson

(Address) 1317 S. Clinton St

Filed OCT 10 1929 G. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8-1929

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to Oct. 8, 1929,

that I last saw her alive on Oct. 8 1929

and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Physical-Signs No

What test confirmed diagnosis? Physical signs

(Signed) J. B. Bronustas M. D. M. D.

10-9-29 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Oct 11 1929

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager st

Spec.—2-29-28—L. F. S.—500 Bks.

E 49944 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49944

CERTIFICATE OF DEATH

47

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1041 Harlem Ave. ST. 16-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Elizabeth Clarvoe

(a) RESIDENCE NO. 1041 Harlem Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F male	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Clarvoe

7 DATE OF BIRTH (month, day, and year) Sept. 15"1857

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	---	24	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Ezra Valentine

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Trone

13 BIRTHPLACE OF MOTHER (city or town) Hanover (State or country) Pa.

Informant Miss Abbie Smith

(Address) 1041 Harlem Ave.

Filed ..., 19 ... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October, 9" 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 28, 1928, to Oct. 9, 1929, that I last saw h alive on Oct. 9, 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast with metastases in Lungs & Brain —

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion, Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Home death

Did an operation precede death? Yes Date of Oct. 1927

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) John T. Owens, M. D.

10/9. 1929 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery.

DATE OF BURIAL Oct. 12 1929

20 UNDERTAKER Harry B. Cook

ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 49945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 49945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 Cooks Lane ST., 28-15 WARD)

2—FULL NAME John Cook

(a) RESIDENCE NO. 709 Cooks Lane ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth D. Cook

DATE OF BIRTH (month, day, and year) November 16, 1833

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	95	10	23	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Freiburg
(State or country) Germany

10 NAME OF FATHER John Cook

11 BIRTHPLACE OF FATHER (city or town) Freiburg
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Graher

13 BIRTHPLACE OF MOTHER (city or town) Freiburg
(State or country) Germany

Informant Mr. John A. Cook

(Address) 713 Cooks Lane

Filed 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 9, 1929, that I last saw h[illegible] alive on Oct 8, 1929, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

10/9. 1929 (Address) 714 Frederick Ave., Catonsville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct. 11 1929
UNDERTAKER [signature]	ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 49946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 49946

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3117 Gwynns Falls Parkway ST.) 46-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Christina Smith

(a) RESIDENCE NO. 3117 Gwynns Falls Pkway ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis Smith

DATE OF BIRTH (month, day, and year) Dec. 18th. 1857

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Erasmus Nelson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Denmark

12 MAIDEN NAME OF MOTHER Barbara (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

Informant E. Lee Reed

(Address) 3117 Gwynns Falls Pkway

Filed 10 1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9" 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1 1929 to Oct 9 1929, that I last saw h[illegible] alive on Oct 9 1929 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum-uterus + bladder

about

CONTRIBUTORY (Secondary) Carcinoma of rectum-bladder + peritoneum uterus (duration) about 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. test + Autopsy

(Signed) W. S. Niblett M. D.

Oct 9/29 19 (Address) 2220 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Oct. 12 1929

B. UNDERTAKER Wm. B. Cook

ADDRESS 1003 West Baltimore St

Spec.—1-12-23—M&T—500 Blks.

E 19947

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19947

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 Forest ST. 10-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Cullen

(a) RESIDENCE No. 731 Forest ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Isabella Cullen (nee Duffy)

6 DATE OF BIRTH (month, day, and year) May 21, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Shoer

(b) General nature of industry, business, or establishment in which employed (or employer) City Yards

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Petersburg Va

PARENTS

10 NAME OF FATHER Patrick Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Cullenan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Isabella Cullen

(Address) 731 Forest St.

15 Filed OCT 9 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1929, to Oct 9, 1929, that I last saw him alive on Oct 8, 1929, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Kirk, M. D.

Oct 10, 1929 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 12, 1929

20 UNDERTAKER ADDRESS

Edmund W. Conkling 924 E Eager

Cor.—10-10-29—A Co.—100 Bks.

E 19948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 19948

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., 73-31 Ward)

2-FULL NAME Bettie Banks

(a) RESIDENCE NO. 117 W Hamburg St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Provident Hosp
(Address) UN

15 Filed 19 G. HAMPSON JONES, M. D., Registrar

E 19329

3954 THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 2nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 117 W Hamburg

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam

(Signed) H. Leitch M. D.

Oct 3 19 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER Commissioner of Health. — ADDRESS OCT 10 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49949

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 3-4 Ward)

REGISTERED NO. 18 E 49949

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Taylor

(a) RESIDENCE NO. 222 S. Dallas St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Black	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
about 49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 089
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Eastern Police
(Address)

15 Certificate received 19 C. HAMPSON JONES, M. D. Registrar

0 1929

3953

THE BORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 28 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intraabdominal Injuries
(Accidently run over by milk Wagon Spring & Gough Sts)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Hamman, M. D.

10/3/29 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 10 19

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19950

CERTIFICATE OF DEATH.

1 8 V E 19950

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Fond Cor 4 Pratt St. 4-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ..... 19 .....

Registrar

OCT 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 30th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Found Shot

Suicide (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) W. J. Fisher M. D.

(Coroner)

Sept 30 , 19 29 (Address) 1654 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

Date of Burial Oct 1 19 29

20 UNDERTAKER Commissioner Health

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19951

CERTIFICATE OF DEATH.

162 E 19951

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 761 Dover St. 21-29 Ward)

2-FULL NAME Infant Carroll

(a) RESIDENCE NO. 761 Dover St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 22 - 29

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER John Carroll

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Jones

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md

14 Informant _____

(Address)

15 Filed _____ 19 _____ C. HAMPSON JONES, M. D. Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to there death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ____ yrs. ____ mos. ____ da.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ da.

(Signed) Eugene Feldt M. D.

(Coroner)

9/24 1929 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY Date of Burial 19

20 UNDERTAKER _____ ADDRESS _____

Commissioner of Health

Cor.—10-10-29—A Co.—100 Bks.

E 19952

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 19952

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 703 Penna Ave St. 17-24 Ward)

2-FULL NAME Bessie Smith.

(a) RESIDENCE NO. 703 Penna Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer) 07
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant (Address) A. W. Police Record

15 Filed 19 O. HAMPSON JONES, M. D. Registrar

01929 The Morgue Balt

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy + Inquiry and that said deceased came to death (Accident, autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 703 Penna Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) H. Leitch Coroner M. D.

Oct 1 19 29 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	19
20 UNDERTAKER	ADDRESS

Commissioner Health

Cor.—10-10-29—A Co.—100 Bks.

E 19953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 19953

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 703 Penna Ave. St., 17-24 Ward)

2-FULL NAME Albert Lynch.

(a) RESIDENCE NO. 703 Penna Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant N. W. Police Record
(Address)

15 Filed OCT 2 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy & Inquiry find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home 703 Penna Ave
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy & Inquiry

(Signed) H. B. Jones, M. D.
Oct 2nd 1929 (Address) Coroner,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

THE MORGUE

Spec.—2-29-28—L. F. S.—500 Blks.

E 49954

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 49954

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 70-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Hankey

(a) RESIDENCE NO. 464 S Pentalum ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year) 10/10/29.

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 1 min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER Jesse Carlton Hankey

11 BIRTHPLACE OF FATHER (city or town) Brunswick
(State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Josephine Steyer

13 BIRTHPLACE OF MOTHER (city or town) Scottsville
(State or country) Va.

Informant Hospital record.

(Address) Franklin Sq. Hospital

Filed 0-1929 G. HAMPSON JONES, M. D.
156. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/29.

17 I HEREBY CERTIFY, That I attended deceased from 10/10/29, 19..., to 10/10/29, 19..., that I last saw h.im alive on 10/10/29, 19..., and that death occurred, on the date stated above, at 12 50 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal chronic nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture + lab. findings

(Signed) Arthur Kallenn, M. D.

, 19 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JS HOPKINS HOSPITAL	
20 UNDERTAKER Bureau of Health.	ADDRESS OCT 10 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49955

129 E 49955

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 323 Ruggold ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Hutchings

(a) RESIDENCE NO. 323 Ruggold ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hutchins

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) md

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

Informant Jos Johnson

(Address) 323 Ruggold ST

Filed C. HAMPSON JONES, M. D. Registrar

0 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7/29

17

I HEREBY CERTIFY, That I attended deceased from 9/22, 1929, to 10/7, 1929.

that I last saw h[illegible] alive on 10/7, 1929

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine ++

(Signed) Dan Oppenheim, M. D.

10/10/29 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-10 1929
20 UNDERTAKER Leonard Easton	ADDRESS 916 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49956

CERTIFICATE OF DEATH

181-004

E 49956

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5503 Carter Ave St. 27-43 Ward)

2-FULL NAME William J. Kanner

(a) RESIDENCE NO. 5503 Carter Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lena Kanner

6 DATE OF BIRTH (month, day, and year) Sep 15/1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	0	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work President
(b) General nature of industry, business, or establishment in which employed (or employer) Holmes Electric Co
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER August Kanner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Kratenfeldt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Lena Kanner
(Address) 5503 Carter Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

OCT 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide Poisoning-Accidental
(Overcome while at work on automobile in his garage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Carnes, M. D.

10/10/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Oct 12 1929
20 UNDERTAKER	ADDRESS
Mc-Mc. J. N. Teufel & Son	801 N. Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

E 49957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49957

REGISTERED NO. 49

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 Piedmont Ave. ST. 15-6T WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hiram S. Schloss

(a) RESIDENCE NO. 3205 Piedmont Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20th. 1856

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Stewart Dept. Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D. C.

10 NAME OF FATHER Seligman Schloss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mena Lazarus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss. Lillie Schloss

(Address) 3205 Piedmont Ave.

Filed 0 T 1929 C. H. AMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9th. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 19th, 1929, to October 9th, 1929, that I last saw him alive on October 9th, 1929, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of left upper ramus of Mandible

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia resulting in circulatory failure (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Not Applicable

Did an operation precede death? No Date of Not Applicable

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Thomas Lonsdale M. D.

, 19 (Address) 1032 E. 36th. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	10/11/ 29

20 UNDERTAKER David Sondheim

ADDRESS 418 Dolphin St. Royal Ave

Spec.—1-12-23—M&T—500 Blks.

E 49958

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49958

CERTIFICATE OF DEATH

159-003

REGISTERED NO.

1-PLACE OF DEATH West Balto Gen Hospt 1067

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Baby Girl Weinstein

(a) RESIDENCE No. 2422 Oakley St ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 1/4 hrs

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/10/29

7 AGE Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Albert Weinstein

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Russia

12 MAIDEN NAME OF MOTHER Belle Goldman

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Russia

14 Informant Hospl Records

(Address)

15 Filed OCT 11 1929 C. HAMPSON JONES, Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 10 . 1929 . to Octo . 1929 .

that I last saw h[illegible] alive on Oct. 10 . 1929 .

and that death occurred, on the date stated above, at [illegible]10A. m.

The CAUSE OF DEATH* was as follows:

Primary Pneumonia

heart failure

resp. failure

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

Oct 10 1929 (Address) W B. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Mt Carmel

DATE OF BURIAL Oct 12 1929

20 UNDERTAKER [illegible]

ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Blks.

E 49959 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md. REGISTERED NO.

CITY OF BALTIMORE: (No. 12-51 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Thurston

(a) RESIDENCE NO. 4833 Raymond St., Seattle, Wash. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) April 22, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Higho"

9 BIRTHPLACE (city or town) Roslyn
(State or country) Washington

PARENTS

10 NAME OF FATHER H. D. Thurston

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wisconsin

12 MAIDEN NAME OF MOTHER Minnie Murphy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna.

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed 1 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 9 19 29

17 I HEREBY CERTIFY, That I attended deceased from July 3 19 29 to October 9 19 29

that I last saw him alive on October 9 19 29

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Lung Abscess

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Abscess of Brain

(duration) yrs. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray - Sputum

(Signed) Allen E. Hazleton M. D.

10/9 19 29 (Address) 104 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U.S. Nat Cem DATE OF BURIAL 10/12 1929

20 UNDERTAKER Robert Brooks & Son ADDRESS Baltimore Md

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49960 — CERTIFICATE OF DEATH — E 49960

74-001

REGISTERED NO. 7331

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 165 W. Hamburg ST. — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Wheeler

(a) RESIDENCE NO. 165 W. Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0+0

9 BIRTHPLACE (city or town) (State or country) Belto

10 NAME OF FATHER James Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Ebey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Annie Hill

(Address) 165 W Hamburg

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1929 to Oct 8 1929.

that I last saw him alive on Oct 8 1929

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) C. H. Fowler, M. D.

Oct 10 1929 (Address) 712 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct 12 1929
20 UNDERTAKER John H. Jordan	ADDRESS [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49961

CERTIFICATE OF DEATH

90 ✓ E 49961

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Somerset Road 2-7-49 WARD) 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clark King Mottu

(a) RESIDENCE NO. 607 Somerset Road ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 7 mos. 24 ds. How long in U. S., if foreign birth? 59 yrs. 7 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard M. Mottu

6 DATE OF BIRTH (month, day, and year) Feb-14-1870

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Calvin J. King

11 BIRTHPLACE OF FATHER (city or town) Carroll Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary L. Goodrick

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

Informant Mrs Leonard M. Mottu (husband)

(Address) 607 Somerset Road. Balto

Filed 19 C. HAMPSON JONES, M.D.

OCT 11 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1929

17

I HEREBY CERTIFY, That I attended deceased from March, 1929, to Oct 9, 1929,

that I last saw h EV alive on Oct 9, 1929,

and that death occurred, on the date stated above, at 8. P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and Myocarditis—

Many (duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas W. Lawrence M. D.

Oct 10, 1929 (Address) 1327 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 11 1929
UNDERTAKER	ADDRESS
Stewart & Company	Balto Md

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49962

CERTIFICATE OF DEATH

45

E 49962

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2003 E. Lombard ST. 2-4 WARD)

2—FULL NAME Amelia Link

(a) RESIDENCE NO. 2003 E Lombard ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Link

6 DATE OF BIRTH (month, day, and year) Aug. 13 1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Nicholas Bayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Iloma Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Amelia Link

(Address) 2003 E. Lombard

15 Filed 11-1929, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Oct. 8, 1929, that I last saw her alive on Oct. 8. 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Intestines)

(duration) 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Eugene L. Peasons M. D.

Oct 9. 1929 (Address) 514 Stony Run

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct. 12 1929
20 UNDERTAKER	ADDRESS
Jos. J. Herr	1506 N. Eutaw

Spec.—2-29-28—L. F. S.—800 Blks.

E 19963 — HEALTH DEPARTMENT—CITY OF BALTIMORE — ✓E 19963

CERTIFICATE OF DEATH — X — 113

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Macek

(a) RESIDENCE NO. Delta - Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 7-1929

7 AGE	Months	Days	If LESS than 1 day, ... hrs. or ... min.
7 Months	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER John Macek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Leona Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed OCT 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4 1929

17 I HEREBY CERTIFY, That I attended deceased from October 4, 1929, to October 10, 1929, that I last saw him alive on October 10, 1929 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

gastro-enteritis -

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. C. Goodwin M. D.

10/10, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery	Oct. 11 1929.
20 UNDERTAKER	ADDRESS
George A. Weber	205 S. Ann St

Spec.—8-16-29—L. F. S.—100 Bks.

E 49964 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 49964

129

REGISTERED NO. 45-58

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Violet Ave ST., 45-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther F. Solomon

(a) RESIDENCE NO. 2811 Violet ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hyman

6 DATE OF BIRTH (month, day, and year): April 1880

7 AGE: Years 48 49 | Months — 6 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 037

9 BIRTHPLACE (city or town) (State or country): Poland

10 NAME OF FATHER: Nathan Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

Informant: Hyman Solomon

(Address) 2811 Violet Ave

Filed 11 1929 19 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1929, to Oct 10 1929, that I last saw h[illegible] alive on Oct 10 1929, and that death occurred, on the date stated above, at 5 30 p.m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis Myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Coronary Sclerosis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Clinical

(Signed) W. A. Bosley, M. D.

Oct 10 1929 Address 3123 Eastwood Rd Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodeph Sholom Cem

DATE OF BURIAL: Oct 11 1929

20 UNDERTAKER: Hof Thomson & Bro

ADDRESS 1127 E Balto St

Spec.—2-29-28—L. F. S.—500 Blks.

E 49965 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49965

CERTIFICATE OF DEATH

185

1—PLACE OF DEATH — REGISTERED NO. 28-65

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Crabbs

(a) RESIDENCE NO. 2005 Wayne Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipyard worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John Crabbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Hospital Record

(Address)

Filed OCT 11 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/9/29

17 I HEREBY CERTIFY, That I attended deceased from 10/7, 1929, to 10/9, 1929

that I last saw him alive on 10/9, 1929

and that death occurred, on the date stated above, at 3 40 a m.

The CAUSE OF DEATH* was as follows:

Fracture Lumbar spine
Traumatic paralysis lower extremities

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

10/9, 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Brick Cemetery	Oct. 11 1929.
20 UNDERTAKER	ADDRESS
H. M. Routson	2235 E Balto

Spec.—2-29-28—L. F. S.—500 Blks.

E 49966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-002 E 49966

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hosp ST. 4-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Dembinsky

(a) RESIDENCE NO. 1514 Ramsay ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Dembinsky (nee Foenes)

6 DATE OF BIRTH (month, day, and year) Feb 22-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer) P R R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Dembinsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Julia Dembinsky

(Address) 1514 Ramsay St

15 Filed Oct 8 1929 H. LINDSAY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1 1929, to Oct 7 1929, that I last saw h[illegible] alive on Oct 4 1929 and that death occurred, on the date stated above, at 1 40 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-2-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Arthur Rathmell M. D.

10/7 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 12 1929

20 UNDERTAKER Harry N. Wetzel 1531 N

ADDRESS Lombard 21

Spec.—2-29-28—L. F. S.—500 Bks.

E 49967

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49967

CERTIFICATE OF DEATH

109-002

1—PLACE OF DEATH

REGISTERED NO. 29

CITY OF BALTIMORE: (No. Franklin Sq Hosp ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earl Thompson

(a) RESIDENCE NO. 1220 Fallis ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1908

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
21		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Self 23

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Arthur M. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lola Easton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Arthur M. Thompson
(Address) 1220 Fallis St.

15 Filed Oct 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 10, 1929, that I last saw h/ alive on Oct 10, 1929 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Vincents angina

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Septic acute pharyngitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical picture

(Signed) Milton Rattner M. D.

10/10, 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Oct. 12, 1929

20 UNDERTAKER Harry V. Wittke, 1531 W Lombard

ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 49968 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49968

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Collington Ave ST. 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Dudley

(a) RESIDENCE NO. 511 N Collington Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Bridget A Dudley

6 DATE OF BIRTH (month, day, and year) 4/8/1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Produce Market

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph T Dudley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER A. M. Dudley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Bridget A Dudley

(Address) 511 N Collington Ave

15 Filed OCT 11 1929 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/9 1929 to 10/10 1929

that I last saw h alive on 10/9 1929

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. Hampson Jones M. D.

10/10/29 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loud Cathedral Cem

DATE OF BURIAL 10/14 1929

20 UNDERTAKER Geo J Ruth Funeral

ADDRESS 1730 Harford Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 49969 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49969

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp 8-17 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Jones

(a) RESIDENCE NO. 1626 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Schneider

6 DATE OF BIRTH (month, day, and year) 4/15/1891

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	38	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Pastry

(b) General nature of indostry, business, or establishment in which employed (or employer) O'Neill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles H. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary A. Weidler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Clara Jones

(Address) 1626 N. Wolfe St

15 Filed 1-1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-29.

17 I HEREBY CERTIFY, That I attended deceased from 10-7, 1929, to 10-9, 1929.

that I last saw h[illegible] alive on 10-9, 1929

and that death occurred, on the date stated above, at 10 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. Congestion

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no. What test confirmed diagnosis? Clinical

(Signed) J. B. Hundley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 10/14/29, 19

20 UNDERTAKER George D. Pentz — ADDRESS 1735 Bank

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49970

CERTIFICATE OF DEATH

185

E 49970

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St., 13 Ward) 1357

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Walker

(a) RESIDENCE NO. 2059 Woodberry Ave. St., 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Delcie C. Walker

6 DATE OF BIRTH (month, day, and year) May 4, 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	44	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) 050
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER John T. Walker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Thompson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Delcie C. Walker
(Address) 2059 Woodberry Ave.

15 Filed 11 1929 19 C. HAMPSON JONES, M. D. Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. skull & L
Accidentally fell drinking Had
shots of whisky

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? M

Did an operation precede death? Date of

Was there an autopsy? M

What test confirmed diagnosis?

(Signed) W. F. Reilly Coroner M. D.

. 1929 (Address) 1637 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct 12 1929
20 UNDERTAKER Horace F. Burgee	ADDRESS 866 Fallsway

Spec.—2-29-28—L. F. S.—500 Blks.

E 49971

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49971

CERTIFICATE OF DEATH

11-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2621 Huntingdon Ave ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME D. Virginia Butcher

(a) RESIDENCE NO. 2621 Huntingdon Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward L. Butcher

6 DATE OF BIRTH (month, day, and year) Sept 17-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of wnrk At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name nf employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elisha Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lina Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. D. Virginia Butcher

(Address) 3519 Eutaw Pl.

15 Filed OCT 11 1929 19 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9-1929.

17

I HEREBY CERTIFY, That I attended deceased from Oct 7th, 19 29, to Oct 9th, 19 29,

that I last saw h alive on Oct 9th, 19 29

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease cnntracted if nnt at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test cnnfirmed diagnosis? Clinical.

(Signed) [illegible], M. D.

Oct 9, 19 29 (Address) 614 W. North Ave

*State the Disease Causing Death, nr in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Oct. 12 1929.

20 UNDERTAKER Horace F. Burgee

ADDRESS 363 Fulton Ave

Spec.—1-10-21—M&T—1500 Blks.

Bernard F. Allers.

E 49972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 49972

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) Mer Gen Hospital 4-33 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Allers

(a) RESIDENCE NO. 1248 Battery Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 (Single) Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28 1915

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or min.
14	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Dead Chas O Allers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Gertrude Kinder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Mrs Rinder

15 Filed OCT 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/1929

17 I HEREBY CERTIFY, That I attended deceased from 10.10.29, 19.., to 10.10.29

that I last saw him alive on 10.10.29, 19..

and that death occurred, on the date stated above, at 12 N P m.

The CAUSE OF DEATH* was as follows: Diabetic Acidosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) [illegible] M. D.

19, 19 (Address) Mer Gen Hospital

*State (1) Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Oct. 14 1929

UNDERTAKER Margaret J. Flynn — ADDRESS 1400 Eutaw Pl

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec- 12-23-21—E.B.R.S.—400 Blks.

E 49973

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49973

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4016 Ridgecroft Rd St., 27-41 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Esterline

(a) Residence No. 4016 Ridgecroft Rd St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, Divorced. (Write the word.) Married

5a-If married, widowed, or divorced—HUSBAND of (or) WIFE of Maggie E. Esterline

6-DATE OF BIRTH (month, day and year) Oct. 3, 1871

7-AGE. 58 yrs. mos. 4 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cigar

(b) General nature of industry, business, or establishment in which employed (or employer) Manf. 045

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Hanover Pa

PARENTS.

10-NAME OF FATHER, Kinnan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penn

12-MAIDEN NAME OF MOTHER, Elvi. Holden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Mrs. Esterline

(Address) 4016 Ridgecroft Rd

15- Filed 1929 C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct-7-1929

17- I HEREBY CERTIFY, That I attended deceased from March 1928 to Oct 7 1929

that I last saw h. alive on Oct 6 1929

and that death occurred, on the date stated above, at 1 34 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs mos 1 ds.

CONTRIBUTORY (Secondary) Epilepsy

(Duration) 2½ yrs mos ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) J. S. Harvey M. D.

19 (Address) 4810 Belair Rd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Parkwood	Oct. 11 1929
20-UNDERTAKER, John A. Inman	ADDRESS 3000 E. Baltimore

INSTRUCTIONS on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49974

CERTIFICATE OF DEATH

129 E 19974

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 S. Linwood Ave. ST., 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lida Lee Schwaner

(a) RESIDENCE NO. 17 S. Linwood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Schwaner

6 DATE OF BIRTH (month, day, and year) Dec. 16/1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51 52		9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Louis Ill.

PARENTS

10 NAME OF FATHER Chas. Wesley Child

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Estelle Marshell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant Henry F. Schwaner

(Address) 17 S. Linwood Ave.

15

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9th 1929

17

I HEREBY CERTIFY, That I attended deceased from March 18 1929 to Oct 9 1929

that I last saw her alive on Oct 9 1929

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis (duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Coma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. Wirth Jr. M. D.

19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct. 12/1929
20 UNDERTAKER Philip Henry	ADDRESS 206 Orleans St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49975

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49975

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hospitals ST. 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Hill

(a) RESIDENCE NO. 1210 Salisbury Alley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 67

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harrison Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed OCT 11 1929, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/5/29

17 I HEREBY CERTIFY, That I attended deceased from 9/26, 1929, to 10/5, 1929, that I last saw him alive on 10/5, 1929 and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) Unknown mos. da.

CONTRIBUTORY (Secondary) Cachexia, bronchopneumonia

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) L. A. Hampson, M. D.

10/6, 1929 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER D.

ADDRESS

Department of Health, OCT 11 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49976

CERTIFICATE OF DEATH

38 E 49976

1—PLACE OF DEATH Balto City Hospitals

CITY OF BALTIMORE: (No. Balto, Md 76-37 ST. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Stewart

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	37 y.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) Balto City Hospitals

15 Filed 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6-29

17

I HEREBY CERTIFY, That I attended deceased from 4-22, 1927 to 10-6, 1929

that I last saw him alive on 10-6, 1929

and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

CONTRIBUTORY (Secondary) Luetic Infection (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Serological & Clinical

(Signed) John F. Strohm M. D.

10/7, 1929 (Address) Bretton City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER D. — ADDRESS

Baltimore Health. OCT 11 1929

Spec.—2-29-28—L. F. S.—600 Blks.

E 49977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 49977

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto. Gen. Hosp. ST. 23-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Megauren

(a) RESIDENCE NO. 1740 S. Ethelbert ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 10 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Megauren

6 DATE OF BIRTH (month, day, and year): Oct. 22 - 1909

7 AGE: Years: 14 yrs (Oct. 22) Months: 10 Days: 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Harry Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Pearl Schillinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Wells

(Address): 1740 S. Ethelbert

15 Filed 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-10-29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1929, to Oct. 10, 1929, that I last saw h[illegible] alive on Oct. 10, 1929, and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Appendicial abscess
Peritonitis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary): Intestinal Obstruction

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Balto, Md

Did an operation precede death? Yes Date of 9-19-29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Edward A. Kemp, M. D.

10-10-1929 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem

DATE OF BURIAL: 10/14/1929

20 UNDERTAKER: J. Frew McCully

ADDRESS: 130 E. Fort

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19978

CERTIFICATE OF DEATH.

129 E 19978

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1265 Sargent (St.) 21-29 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hix

(a) RESIDENCE No. 1265 Sargent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah.

6 DATE OF BIRTH (month, day, and year) Sept 13 1853

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) B&O

(c) Name of employer B. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Grafton Hix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary M. Ramsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Beulah Hix (Address) 1265 Sargent St.

15 Filed 1 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Oct 11, 1929, that I last saw him alive on Oct 9, 1929, and that death occurred, on the date stated above, at 2-a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Chronic Myocarditis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. D. Easton, M. D.

(Address) 301 E Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Oct 17 1929

DATE OF BURIAL

20 UNDERTAKER Wm Cole & Sons

ADDRESS Balto.

Fill out very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

131 E 49979

1—PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hosp. 19-18 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Anna Mettee

(a) RESIDENCE NO. 1718 Holbrook Lt. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE Andrew H Mettee

6 DATE OF BIRTH (month, day, and year) Sept 17, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Offmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Myrtle Mettee

(Address) 1718 Holbrook St

15 Filed OCT 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10, 29

17

I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to Oct 10 —, 1929.

that I last saw her alive on Oct 10 —, 19 29

and that death occurred, on the date stated above, at 8 45 a.m.

The CAUSE OF DEATH* was as follows:

Pyelitis

Fatty infiltration of Obstruction

(duration) yrs. 3-5 mos. ds.

CONTRIBUTORY (Secondary) Coronary Embolism

(duration) yrs. Few minutes mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 8-7-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I M Hendrix, M. D.

19 (Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL 10/21 1929

20 UNDERTAKER

ADDRESS 1217 St Paul St

Spec.—1-12-23—M&T—500 Bks.

E 49980 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 19980

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 110 Scott ST. 18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Kruer

(a) RESIDENCE NO. 110 Scott ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Herman G. Kruer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Wahme

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman G. Kruer (Address) 110 Scott St.

15 Filed OCT 11 1929, 19 [illegible] Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 1929

17

I HEREBY CERTIFY, That I attended deceased from April, 1928, to Oct 8, 1929, that I last saw h alive on Oct 8, 1929, and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor.

(duration) 2 yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? Date of July, 1928

Was there an autopay? yes.

What test confirmed diagnosis? clinical + autopsy

(Signed) Thos Madden, M. D.

, 19 (Address) 1031 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M. D. Christ — DATE OF BURIAL Oct 12 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St. Paul St.

FOR IS very important. See instructions on back of certificates. Exact statement of occu-

Spec.—1-12-23—M&T—500 Bks.

E 19981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-801

74 E 19981

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No. 1000 Caton Ave. St.) (12-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. McKannar

(a) RESIDENCE NO. 1717 St. Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, ~~or Divorced~~ (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie McKannar

6 DATE OF BIRTH (month, day, and year) June 6 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or.. min.
	73	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James McKannar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Bowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jenkins Memorial Hosp

(Address) 1000 Caton Ave

15 Filed ..., 19 1929 R.H.A. Registrar

C. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1929, to Oct. 9, 1929, that I last saw him alive on Oct. 9, 1929, and that death occurred, on the date stated above, at 9-25 P m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cathedral

DATE OF BURIAL 10/12 1929

20 UNDERTAKER H M Cook

ADDRESS 1217 N Fulton Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49982

CERTIFICATE OF DEATH

118-002

E 49982

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1443 N. Fulton St. 15-21 Ward)

2-FULL NAME Donald F. Schmoll.

(a) RESIDENCE NO 1443 N. Fulton St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 25-1925

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	4	5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Richard Schmoll

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Blanche Roberts

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Blanche Schmoll
(Address) 1443 N. Fulton

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, ~~and year~~) Oct 10 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Chas. Sinns M. D.

Oct. 10 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 10/12 1929

20 UNDERTAKER H. M. Cook

ADDRESS 1217 Park

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Sapp

E 49983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 49983

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 E. Biddle ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth A. Sapp

(a) RESIDENCE NO. 1620 E. Biddle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel O. Sapp

6 DATE OF BIRTH (month, day, and year) Nov. 30-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER David Carback

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bond

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mary Edith Sapp
(Address) 1628 E. Biddle St

15 Filed 10 11 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 | 29

17

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929, to Oct 10, 1929, that I last saw h[illegible] alive on Oct 10, 1929, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct 11. 1929 (Address) 1834 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery,	Oct. 14, 1929,

20 UNDERTAKER Wm. C. Black ADDRESS 921 N. Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

E 49984

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 49984

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 4-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Post

(a) RESIDENCE NO. 259 Pratt st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Post

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records
(Address)

15 Filed 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1929 to Oct. 9, 1929, that I last saw him alive on Oct. 9, 1929 and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) [illegible], M. D.

10-9, 1929 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Oct 11 1929
20 UNDERTAKER John J. Fahey Son	ADDRESS 1318 Light St

Cor.—10-10-29—A Co.—100 Bks.

(Bauernwise)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49985

CERTIFICATE OF DEATH

E 49985

1-PLACE OF DEATH

City of Baltimore: (No. St. Jos Hosp St., 4-16 Ward)

2-FULL NAME Mary L. S. Bauernschmidt

(a) RESIDENCE NO. 2636 Hoffman St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

REGISTERED NO. 188-103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (Write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chr. Bauernschmidt

6 DATE OF BIRTH (month, day, and year) Nov 26 - 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hawk
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Philip Marquart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Alfred H Kaufman
(Address) 5604 Fair Oaks Ave

15 Filed 11 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract L. Arm Comp. Comm. Struck by auto about 16 Ft from intersection when crossing street at right (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Multiple Contusions

Causing Traumatic Shock (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Accident + Eastern

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. J. Bauer, M. D.

10/11, 1929 (Address) 2939 W Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Conn	10/14 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 E Pratt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 19986

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 10-W ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George P. Johnston

(a) RESIDENCE NO. 1028 N. Central ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unkno Wn yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Johnston

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stage hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Maryland Theatre

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marcella Byrn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address)

15 Filed 11 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to Oct. 11, 1929, that I last saw him alive on Oct. 11, 1929 and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) [illegible] M. D.

10-11 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral

DATE OF BURIAL 10/14 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E. Pratt St

(Instructions on back of certificate.)

Spec.—I-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49987

CERTIFICATE OF DEATH.

24-002

24 E 49987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital WARD) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C Laws

(a) RESIDENCE No. 1413 Myrtle Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Carrie Laws

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer D.C.

(b) General nature of industry, business, or establishment in which employed (or employer) Navy Yard.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middlesex Va.

PARENTS

10 NAME OF FATHER John Laws

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Martha Bandy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Sister

(Address)

15 Filed 11-1929 C. HAMPSON JONES, M. D. Registrar

By AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 28 1929 to Oct 10 1929

that I last saw him alive on Oct 10 1929

and that death occurred, on the date stated above, at 8-20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Disease Pulmonary Embolism

(duration) about yrs. 2 mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? X-ray & autopsy

(Signed) George McDonald M. D.

19 Address Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 10/12/1929

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1617 Druid Hill

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49988

CERTIFICATE OF DEATH

185 ✓

E 49988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. West Balto Gen Hosp; Ward)

2-FULL NAME John E Kelly

(a) RESIDENCE NO. 1422 Light St, 23-33 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Kelly.

6 DATE OF BIRTH (month, day, and year): Mar 12-1881

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	48	6	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Helper on Ice Wagon
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: 086

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Geo Kelly.

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Gumpman

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant (Address) Margaret Kelly Homewood Cathedral

15 Filed ..... 19.. C. THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 11 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Accidently fell off back of Ice wagon Fractured Skull

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted? If not at place of death, give former residence: Rear 2700 Edmondson Ave

Did an operation precede death? yes Date of Oct 10

Was there an autopsy? no

What test confirmed diagnosis? Regular

(Signed) H. E. Funk, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Oct 12 1929
20 UNDERTAKER	**ADDRESS**
Margaret G. Flynn	1422 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19989

CERTIFICATE OF DEATH

90

E 19989

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 N. Calvert ST., WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Ellsworth Starr

(a) RESIDENCE NO. 1702 N. Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer) 055

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. (State or country) Md

PARENTS

10 NAME OF FATHER George Starr

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Valluria Carter

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Starr Matthews

(Address) 1702 N. Calvert St.

15 Filed ....., 19.... Per C. HAMPSON JONES, M. D. ....., Registrar

12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1924, to Oct 10, 1929, that I last saw h alive on Oct 10, 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Calv Endocarditis with Myocarditis (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jefferies Brack, M. D.

1912, 1929 (Address) 5 Club Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Oct 12 1929

20 UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 49990

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2137 N. Carey ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Edward Taylor

(a) RESIDENCE NO. 2137 N. Carey ST., 17 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgeanna Taylor

6 DATE OF BIRTH (month, day, and year) Mar. 3 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wicimoco Co Md.

PARENTS

10 NAME OF FATHER Wesley Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Paul Taylor

(Address) 152 Lakeside Ave

Filed 12 1929, 19 at [illegible] M.

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 19 29 to Oct. 11, 19 29

that I last saw h[illegible] alive on Oct. 10, 19 29

and that death occurred, on the date stated above, at 5.20 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) - yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry E. Wilson M. D.

19 (Address) 13 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Highlands Md	Oct. 13 1929
21 UNDERTAKER Wm. Thicker Sons	ADDRESS Havelock

Spec.—2-29-28—L. F. S.—500 Blks.

E 49991 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

36-002 E 49991

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. ~~Fremont Avenue~~ 1610 W. North Ave. ST. WARD) 15-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Bertram Jr.

(a) RESIDENCE NO. 1610 W. North Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Belle Whippy Bertram

6 DATE OF BIRTH (month, day, and year) Nov 26 1876

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	52	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chas. Bertram

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Loretta Grome

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Belle Bertram

(Address) 1610 W. North Ave

15 Filed 10 2 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct, 19 28, to Oct 10, 19 29, that I last saw h alive on Oct 9th, 19 29 and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Cor. Coronary Thrombosis

Hard due to senile Changes and old Lues Cerebri (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Mandible (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fell from Streetcar

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) E. L. Jones, M. D.

10/4/0. 1929 (Address) 1606 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Oct. 12 1929
UNDERTAKER Wm. J. Hickner Sons	ADDRESS Norfolk Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 19992 HEALTH DEPARTMENT—CITY OF BALTIMORE E 19992

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

2-FULL NAME Thomas E. Lambert

9-47

(a) RESIDENCE NO. 3617 Greenmount Ave. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alberta J. Lambert (Stevens)

6 DATE OF BIRTH (month, day, and year) Dec. 8, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Former sea captain

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

0816

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Elijah Lambert

11 BIRTHPLACE OF FATHER (city or town) St. Michael's (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte Parker

13 BIRTHPLACE OF MOTHER (city or town) St. Michael's (State or country) Maryland

14 Informant Hospital record (Address)

15 Filed OCT 12 1929, 19 C. HAMPSON JONES, M.D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1929, to October 11, 1929, that I last saw him alive on October 11, 1929, and that death occurred, on the date stated above, at 5 50 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Diabetes; decubitus ulcer (duration) — yrs. — mos. ? ds.

18 Where was disease contracted if not at place of death? at home (residence)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) ..... M. D.

(Address) .....

*State the Disease Causing Death, or in deaths from Violence Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct. 14 1929

20 UNDERTAKER Wm. J. Tickner & Son

ADDRESS N. Y. Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49993

CERTIFICATE OF DEATH

100-001 E 49993

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John D. Starr (John Drennen Starr)

(a) RESIDENCE NO. Hotel Kernest St. 4-25 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minna Crodall Starr

6 DATE OF BIRTH (month, day, and year) Apr 17 - 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fort Smith (State or country) Arkansas

PARENTS

10 NAME OF FATHER Col. Wm. H. Starr

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes C. Robinson

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. Agnes S. Bayley (Address) Middleton Md

15 Filed ....., 19.... C. HAMPSON JONES, M.D. Registrar

DEC 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-29

17 I HEREBY CERTIFY, That I attended deceased from 10-7 ..., 1929, to 10-9 ..., 19 29

that I last saw h... alive on 10-9 29 ..., 19

and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. McGuire M. D.

10/12, 1929 (Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct. 12 1929
20 UNDERTAKER Wm. J. Tuckerman	ADDRESS N. Y. Pa.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 49994

HEALTH DEPARTMENT—CITY OF BALTIMORE

1929 90 E 49994

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Joseph Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary J. O'Dea 16-68

(a) RESIDENCE NO. 2733 Eager ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Thomas Dunne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Cole

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Estelle L. Odell

(Address) 2733 Eager St

15 Filed 12 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to Oct 9, 1929.

that I last saw h alive on Oct 7, 1929

and that death occurred, on the date stated above, at 5:10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10/7/29

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) S H Barranco, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 11 19 29
20 UNDERTAKER	ADDRESS
J. H. Nugent	1502 Eutaw St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 49995

CERTIFICATE OF DEATH

199 E 49995

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 815 China St. St., Ward)

2-FULL NAME Samuel Bolar.(C)

(a) RESIDENCE NO. 1234 S. Eutaw St. St., 21-31 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. [redacted] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed or divorced
HUSBAND of [redacted] Minnie Bolar.(C)

6 DATE OF BIRTH (month, day, and year) September 17, 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	27	0	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Bolar.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Iola Bradley.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina.

14 Informant Minnie Bolar.(C) wife.
(Address) 1627 Baker St.

15 Filed OCT 12 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 5, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the skull, struck by a brick, Homicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquest

(Signed) Otto Leimandt, M. D.

10/10 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct 12 1929
20 UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans St

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

Morris Thompson W.B. 0377 2/101-901

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 19996

E 19996

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1532 Orleans St., Ward) 6-9

2-FULL NAME Morris Thompson

(a) RESIDENCE NO. 1532 Orleans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/22/31

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
About 31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) English West Africa

PARENTS

10 NAME OF FATHER Morris Thompson

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) West Africa

12 MAIDEN NAME OF MOTHER
Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) West Africa

14 Informant Kofi Appiah (cousin)
(Address) 1021 McElderry St.

15 Filed ..(.) 1911 C. HAMPSON JONES, M. D. Registrar

12 1929 By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure-Probably Pneumonia

(History of Pleurisy 3 months ago)

..... (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. H. Pollitt, M. D.

10/11/29 19 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Oct 12th 1929
20 UNDERTAKER	ADDRESS
Ida Snyder	1708 Madison St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 19997

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

E 19997

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2243 E. Biddle ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Anna Ewa Dubs

(Residence in Baltimore: No. 2243 E Biddle St.: 60 yrs. 8 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Jan 27 (Month) (Day), 1865 (Year)

7 AGE: 64 yrs. 8 mos. 14 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Ga

PARENTS

10 NAME OF FATHER: Henry L. Kramer

11 BIRTHPLACE OF FATHER (State or country): Ga

12 MAIDEN NAME OF MOTHER: Caroline Nisi

13 BIRTHPLACE OF MOTHER (State or country): Ga

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C Augustus Dubs

(Address) 2243 E Biddle St

15 Filed OCT 12 1929 C. HAMPSON JONES, M. D. 191 Per ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 11 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Oct 11, 1929, that I saw h[illegible] alive on Oct 11, 1929, and that death occurred, on the date stated above, at 0145 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) yrs. 12 mos. ds

Contributory (SECONDARY) Diabetes

(Duration) 1 yrs. mos. ds.

(Signed) Denis Donoghue M. D.

Oct 11, 1929 (Address) 708 N Wolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park DATE OF BURIAL: Oct 14, 1929

20 UNDERTAKER: Philip Henry ADDRESS: 2016 Orleans St

1.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 49998

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

44 E 49998

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6003 Edmondson Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Crampton 27-43

(a) RESIDENCE NO. 6003 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John J.

6 DATE OF BIRTH (month, day, and year) Mar 24/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Knaup

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs C. F. Jetts

(Address) 6003 Edmondson Ave

Filed OCT 12 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11/1929

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to Oct 11, 1929, that I last saw h[illegible] alive on Oct 10, 1929 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Bright's Kidney Disease (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones, M. D.

10/11. 1929 (Address) 2701 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct 14, 1929
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 49999 HEALTH DEPARTMENT—CITY OF BALTIMORE E 49999

CERTIFICATE OF DEATH. 146

REGISTERED NO.

1-PLACE OF DEATH 2230 Orleans St

CITY OF BALTIMORE: (No.) ST., WARD)

2-FULL NAME Caroline T. Greenwell 6-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2230 Orleans ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Greenwell

6 DATE OF BIRTH (month, day, and year) Sept. 26, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Christian Merlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Catharine Cantow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant George Greenwell (husband)

(Address) 2230 Orleans St.

15 Filed OCT 12 1929, 19 C. HAMPSON JONES, M. D. Registrar

RPR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1929, to Oct 11, 1929, that I last saw h[illegible] alive on Oct 10, 1929, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia.

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Premature Delivery (2 mo.)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. C. Schiliro M. D.

Oct. 12, 1929 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 14-29
20 UNDERTAKER Philip Herring	ADDRESS 3066 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 lbs.

E 50000 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50000

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caton & Welkeas Avenues ST., WARD 17-50

2-FULL NAME Mrs Pricilla Vardy.

(a) RESIDENCE NO. 105 E. 33rd St City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced; (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph J. Vardy

6 DATE OF BIRTH (month, day, and year) Feb 6/1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jacob Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Cecilia - -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Harry Griggs

(Address) 105 E. 33rd St

15 Filed OCT 1929, 19 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-10 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-7, 1929, to 10-10, 1929, that I last saw her alive on 10-10, 1929 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Oct 14, 19 29

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T 12 1929

Spec.—1-12-23—M&T—500 Bks.

Lo-1965-2.30

E 50001 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50001

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 119 W Hughes St. ST., 22 WARD) 27-31

2-FULL NAME Sarah Ewing

(a) RESIDENCE NO. 119 Hughes ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Cook 021

(c) Name of employer

9 BIRTHPLACE (city or town) unknown
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Mrs. J. Brown
(Address) 119 W. Hughes st

15 Filed OCT 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/1929

17 I HEREBY CERTIFY, That I attended deceased from 10/9/, 1929, to 10/10/, 1929, that I last saw h[illegible] alive on 10/10/, 1929, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation
Pulmonary Edema
Acidosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Pancreatitis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical History

(Signed) Mrs. Bishop M. D.

, 19 (Address) 709 Hughes st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvert - Cel

DATE OF BURIAL 13 1929

20 UNDERTAKER R L Paden

ADDRESS [illegible]

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

E 50002

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard Brockmeyer

(a) RESIDENCE NO. 2010 Ellsworth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-26-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Houck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 12 1929 C. H. JAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-11-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1929, to Oct 11, 1929

that I last saw h. alive on Oct 11, 1929

and that death occurred, on the date stated above, at 7.35 P m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. C. Goodwin, M. D.

10/11, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Oct 14 1929

20 UNDERTAKER John Ulmt

ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

E 50003

HEALTH DEPARTMENT—CITY OF BALTIMORE

9 E. 50003

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 356 Cleveland St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Thomas 21 Y

(a) RESIDENCE NO. 356 Cleveland WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

4a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) Out

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benj Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nellie Thomas
(Address) 356 Cleveland

15 Filed OCT 12 1929, 19.... Per ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11-29

17 I HEREBY CERTIFY, That I attended deceased from 10/9/29, 19.... to 10/11/29, 19.... that I last saw h.... alive on 10/11/29, 19.... and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

.... (duration) .... yrs. .... mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough

.... (duration) .... yrs. .... mos. 16 ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? .... Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) Hereford Dean, M. D.

, 19.... (Address) 727 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Albion Cemetery	10/12 19 29
20 UNDERTAKER Walter B. Spriggs	ADDRESS 139 W. Lanvale St.

CT 12 1929

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E. 50004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X117

E. 50004

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. St. Joseph's Hospital ST., WARD)

2—FULL NAME Mr. Joseph McGrath 9-17

(a) RESIDENCE NO. Woodstock College, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 15 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	30	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Studying for Priesthood.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital records.

(Address)

Filed OCT 12 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12/29

17

I HEREBY CERTIFY, That I attended deceased from 10-7, 1929, to 10-12, 1929,

that I last saw h[illegible] alive on 10-12, 1929

and that death occurred, on the date stated above, at 1 50 a.m.

The CAUSE OF DEATH* was as follows:

Appendiceal abscess

(duration) yrs. mos. 7-9 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 12 hrs ds.

18 Where was disease contracted if not at place of death? 10-5-29

Did an operation precede death? Yes Date of 10-11-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Sundriz, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodstock Md.	10-14 1929
20 UNDERTAKER	ADDRESS
Bernard C Hart	1000 S Eden St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50005 E 50005 E 50005 E 50005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital WARD)

2-FULL NAME Charles Grafton Hill

(a) RESIDENCE No. Newinsoh, Md St., 14 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Bessie Hall

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md.

PARENTS

10 NAME OF FATHER: John Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick, Md

12 MAIDEN NAME OF MOTHER: Lottie Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick, Md

14 Informant: Sister

(Address)

15 Filed OCT 13 1929 C. HAMPSON JONES, M. D. Registrar

By: GKE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 12, 1929, that I last saw h(e)(i) alive on Oct 12, 1929, and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Typhoid

(duration) yrs. short mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Widal Culture (Blood)

(Signed) Geo. McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old Field	Oct 14 1929
20 UNDERTAKER	ADDRESS
L. H. Steiner	New Windsor Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 50006 E 50006 #50006 E 50006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 47

REGISTERED NO. 70

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard & Kelly Hospital ST., WARD 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Wilkins Dalby

(a) RESIDENCE NO. Bridgetown, Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 weeks yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ William Lee Dalby

6 DATE OF BIRTH (month, day, and year) Dec 28 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42	42	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bridgetown, Va.

PARENTS

10 NAME OF FATHER John T. Wilkins II

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Betty Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Florence Wilkins Stevenson (Address) Bridgetown Va (sister)

15 Filed OCT 13 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929 19 . to Oct 12 . 1929 .

that I last saw h alive on Oct 12 . 1929

and that death occurred, on the date stated above, at 10:15 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left breast metastases to Left lung.

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) metastases to lungs

(duration) yrs. 2 mos. ds.

18 Where was disease contracted? if not at place of death? Va.

Did an operation precede death? yes Date of Feb 16, 1929

Was there an autopsy? no

What test confirmed diagnosis? microscopic section

(Signed) Edmund Kelly, M. D.

Oct 12 1929 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bridgetown Va	Oct 13 1929
20 UNDERTAKER	ADDRESS
Chas. J. Black	742 W. Fayette St

MARGIN RESERVED FOR BINDING

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E. 50007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 50007

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2212 Ryan St., WARD) 16 68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Larrimore

(a) RESIDENCE NO. 2212 Ryan ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 13th 1929

7 AGE: Years: few minds | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Raymond D. Larrimore

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Agnes E. Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mother

(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

OCT 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 12 1929, to Oct 12 1929, that I last saw h[e] alive on Oct. 12 1929, and that death occurred, on the date stated above, at about 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

Premature birth.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 1215 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — DATE OF BURIAL: Oct 13 1929

20 UNDERTAKER: H. St. C. Dippel Inc. — ADDRESS: 38 S. Eutaw St.

Spec.—1-10-21—M&T—1500 Blks.

E 50008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

147

E 50008

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Lottie O'Brocki 25-77

(a) RESIDENCE No. 1616 Church St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leopold Obrocki

6 DATE OF BIRTH (month, day, and year) June 20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 631

(c) Name of employer At. Home

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Raphel Szymanowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Pelagia Ploszynska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Leopold Obrocki

(Address) .....

15 C. HAMPSON JONES, M. D.

OCT 13 1929 19 P.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1929 to Oct 10 1929.

that I last saw her alive on Oct 10 1929

and that death occurred, on the date stated above, at 6 40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. Alexander Morey M. D.

10/10. 1929 (Address) 24 24 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL 10/14 1929

UNDERTAKER Wm Fiaelkowski — ADDRESS 148 Eastern

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E. 50009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50009

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO. E 50009

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Bertie M. Councill

9-17

(a) RESIDENCE No. 3635 Greenmount Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene K. Councill

6 DATE OF BIRTH (month, day, and year) October 27, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Matthews County, Virginia

PARENTS

10 NAME OF FATHER Francis Kemp

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy V. Richardson

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Virginia

14 Informant Hospital records (Address)

15 Filed OCT 13 1929 C. H. BROOKS JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1929

17 I HEREBY CERTIFY, That I attended deceased from October 7, 1929, to October 11, 1929, that I last saw her alive on October 11, 1929, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic cardiovascular renal disease (duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) Geo. [illegible] M. D.

(Address) [illegible] Forest Hough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Oct. 14 1929

20 UNDERTAKER Joseph Hook

ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 500 10

CERTIFICATE OF DEATH

101-001

REGISTERED NO. E 500 10

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Tyson ST., WARD) 11-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosetta Bailey

(a) RESIDENCE NO. 524 Tyson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 2 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Bailey

6 DATE OF BIRTH (month, day, and year) July 16, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER James Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sedonia Garrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Walter Bailey

(Address) 524 Tyson St

15 Filed OCT 13 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 6, 1929, to Oct 10, 1929, that I last saw her alive on Oct 9, 1929 and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Macco Williams, M. D.

Oct 10 1929 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Oct 13 1929
20 UNDERTAKER Samuel Wemley	ADDRESS 1012 Bolton

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50911

CERTIFICATE OF DEATH

129

E 50911

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 E Chase ST., WARD) 10-14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William B. Gibson

(a) RESIDENCE NO. 817 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman. Retired

(b) General nature of industry, business, or establishment in which employed (or employer) C&P

(c) Name of employer Western Union

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John R Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Waller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Joseph P Gibson

(Address) Walbrook Md

15 Filed OCT 13 1929, 19 C. HEMPSON JONES, M. D. Registrar

Per EFG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 12, 1929

that I last saw h[illegible] alive on Oct 11, 1929

and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Congenital Deafness

Don't know (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Rheumatism & Neuritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W K Carnsley, M. D.

Oct 13 1929 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	10/14 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 50912 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50912

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 253 Half Moon Alley ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlett Hamelton 5-4

(a) RESIDENCE NO. 203 Half Moon Alley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Williams Hamelton

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wilmington N.C.

PARENTS

10 NAME OF FATHER Charles McRaee

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER U

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Edwina Robinson
(Address) 608 Lawrence St

15 Filed ..... By C. HAMPSON JONES, M. D. Registrar

OCT 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929, to Oct 11, 1929, that I last saw h alive on Oct 11, 1929 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Triplitis

(duration) yrs. mos. 30 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Dr Adel

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

10-12-1929 (Address) 508 [illegible] St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-14 1929
20 UNDERTAKER	ADDRESS
Bryson & Wright	1218 McCulloh St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50013 X 153 E 50013

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital, Balto. Md. REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., WARD) 4 30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Sherman

(a) RESIDENCE NO. Savage, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 - 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Frank Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Shebel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Frank Sherman

(Address) Savage Md

15 Filed OCT 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Oct 12, 1929, that I last saw him alive on Oct, 12, 1929 and that death occurred, on the date stated above, at 9 10 a.m.

The CAUSE OF DEATH* was as follows:

Multiple abscess of L. thigh

pylemia

(duration) yrs. mos. 4 2 ds.

CONTRIBUTORY (Secondary) septicaemia (staphylococcus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Savage Md

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) C. W. Peake M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md DATE OF BURIAL Oct 14th 29

UNDERTAKER D. Boyd Lucas ADDRESS Laurel Md.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Byron

E 5-0014

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5-0014

CERTIFICATE OF DEATH

161-002

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., _____ Ward) 7-28

2-FULL NAME Robert B. Byron

(a) RESIDENCE NO. 2018 Eagle St., _____ Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10/29

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Robert Byron

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Md

12 MAIDEN NAME OF MOTHER Marie -----

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Md

14 Informant Hopkins Records
(Address)

15 Filed _____, 19 _____ C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage of Birth

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY _____
(Secondary)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? yes

What test confirmed diagnosis? _____

(Signed) _____, M. D.

10/12/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct 14 1929
20 UNDERTAKER	ADDRESS
John Feldmeier & Sons	1200 N Fulton Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 31 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 50015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 101-001

REGISTERED NO. E 50015

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 Druid Hill Ave St., WARD) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Harriet S. Coard

(a) RESIDENCE NO. 2015 Druid Hill Ave St., WARD 14 Phila Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 days How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Maria Ward Evans

(Address) 2015 Druid Hill

15 Filed OCT 13 1929 C. HAMPSON JONES, Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 8th, 19 29, to Oct 10th, 19 29, that I last saw her alive on Oct 10th, 19 29 and that death occurred, on the date stated above, at 10 5 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1231 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	10/13/1929
20 UNDERTAKER	ADDRESS
Mrs. Geo H. Holland	1631 Druid

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E50016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E50016

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3138 O'Donnell St., Ward 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Schmidt

(a) RESIDENCE NO. 3138 O'Donnell St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXXXXXXXXX

6 DATE OF BIRTH (month, day, and year) Feb. 17 1858

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	71	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer 40

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Germany

14 Informant Mrs. Augusta Blei

(Address) 3138 O'Donnell St.

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D.

Registrar

OCT 13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) Eugene Zeller, M. D.

(Coroner)

10/12/29 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — Date of Burial Oct 13, 29

20 UNDERTAKER John F Demy — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50017 49

CERTIFICATE OF DEATH

49 E 50017

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD) 15-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugenia Bratt

(a) RESIDENCE NO. 2212 Garrison Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-23-74

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel H. Bratt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER Mary A. Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Date received OCT 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11-1929

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to Oct 11, 1929, that I last saw her alive on Oct 11, 1929 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma (thyroid gland neck)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Exam

(Signed) E. Krumbhaar, M. D.

Oct 11, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Oct. 14 1929
UNDERTAKER John O. Mitchell Sons	ADDRESS 1900 Eutaw Place

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 50018 ✓

E 50018

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N. Gilmor ST., WARD) 19-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Howard

(a) RESIDENCE NO. 516 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): July 5-1908

7 AGE: Years 21 | Months 2 | Days 3 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltd md

PARENTS

10 NAME OF FATHER: Wm Howard.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Dollie Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Rebecca Rowley

(Address): 516 N. Gilmor

Filed OCT 13 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct 10 29

17 I HEREBY CERTIFY, that I attended deceased from Aug 19, 1929, to Oct 10th 1929 that I last saw her alive on Oct 10th 1929 and that death occurred, on the date stated above, at 11.35 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. E. Smith, M. D.

Oct 11 1929 (Address) 1015 Bolton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Oct 14th 1929

UNDERTAKER: D. E. Jones

ADDRESS: 111 S Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50019 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50019

CERTIFICATE OF DEATH

34

E 50019

E 50019

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Baltimore City Hosp. ST., WARD 21-39

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry E. Zeinelman

(a) RESIDENCE NO. 1232 Cleveland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie M. Zeinelman

6 DATE OF BIRTH (month, day, and year) Sept 19 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ticket salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 66

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER August Zeinelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Zimick

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hospital Record

(Address)

15 Filed OCT 3 1929, 19.. C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10/29

17 I HEREBY CERTIFY, That I attended deceased from 12/1/9, 19 28, to 10/10, 19 29, that I last saw him alive on 10/10, 19 29 and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Pott's disease lower dorsal spine

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. C. Lumpkin, M. D.

10/11, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Oct 15 1929
20 UNDERTAKER	ADDRESS
By Mrs. John M. Turpin & Son	501 N. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50020 ✓ E 50020

E 50020

CERTIFICATE OF DEATH

5/ E 50020

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1227 N. 62nd ST., WARD) 26 - 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Vickers

(a) RESIDENCE NO. 1727 N. 62nd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin Vickers

6 DATE OF BIRTH (month, day, and year): Jan 8, 1881

7 AGE — Years: 48 | Months: 9 | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 027

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: J. L. Byrd.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary E. Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Jessie May Masel

(Address) 1227 N. 62nd St.

15 Filed: OCT 13 1929 — C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 10/29.

17 I HEREBY CERTIFY, That I attended deceased from Oct 8 — 1929, to Oct 10, 1929.

that I last saw h[illegible] alive on Oct 10, 1929

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetic coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease cuntracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. V. Moore M. D.

, 19 (Address) Crossville Va

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn — DATE OF BURIAL: Oct. 14 1929.

20 UNDERTAKER: E. Mrs. John W. Teufel Son — ADDRESS: 801 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50021 E 50021 90 E 50021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3312 Rosekemp Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E. Schmidt 29-44

(a) RESIDENCE NO. 3312 Rosekemp ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Schmidt

6 DATE OF BIRTH (month, day, and year) Mar 2. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76.	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired old

(b) General nature of industry, business, or establishment In which employed (or employer) Cabinet Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Emanuel Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Louisa Schmidt

(Address) 3312 Rosekemp Ave

15 Filed OCT 13 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to Oct 10th, 1929, that I last saw him alive on Oct 10th, 1929, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L. L. Leady. M. D.

10-10, 1929 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 14, 1929.
20 UNDERTAKER	ADDRESS
Mrs. John W. Tenfelder Son	801 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 50022 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50022

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST. 25-72 WARD

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie P. Hayward

(a) RESIDENCE NO. 1661 Creighton Place ST., WARD West. N. La.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mulford M. Hayward

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sparkville, Tenn.

PARENTS

10 NAME OF FATHER Robt. L. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sparkville Tenn

12 MAIDEN NAME OF MOTHER Roselie Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sparkville Tenn

14 Informant Jenkins Memorial Hosp
(Address) 1000 Caton Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1929, to 10-13 1929, that I last saw h[illegible] alive on 10-13-29, 19 and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gallean Cemetery - Ridgewood N.J.	10-14-29
20 UNDERTAKER Martin Fahey & Sons.	ADDRESS 1827 W North Ave.

CT FEB 4 1929 C. HAMPSON JONES, M. D.

Mrs. Hugh Smith 6462 Va Pa R.R.

WRITE PLAINLY, WITH CARBON INK. THIS STATEMENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50023

CERTIFICATE OF DEATH

E 50023

1-PLACE OF DEATH

City of Baltimore: (No. Balto. City Hospital St., Ward) 90

REGISTERED NO. 1-21

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Druitt

(a) RESIDENCE NO. 562 St. Mary's St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R Druitt

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town)
(State or country) Balto - Md

PARENTS

10 NAME OF FATHER Cornelius B Hall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Rosie Smith
(Address) 562 St Mary's St

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

10/14. 1929. (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvery	Oct 14 1929
20 UNDERTAKER	ADDRESS 1027 Lombard St
John H Toadvine	

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50024 ✓

E 50024

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4 N. Spring ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian M. Brown

(a) RESIDENCE NO. 4 N. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Brown

6 DATE OF BIRTH (month, day, and year) Oct. 20-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Tom Young

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Hester Ellis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Joseph Brown

(Address) 4 N. Spring St.

15 Filed OCT 14 1929 LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 10th, 1929, to Oct 12th, 1929, that I last saw h.e alive on Oct 12th 1929 and that death occurred, on the date stated above, at 6.40 P m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Warner, M. D.

1013 Linden Ave (Address) 308 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Oct. 14 1929
20 UNDERTAKER Chas. H. Johnston	ADDRESS 416 N. Carey St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50025 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50025

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 90

CITY OF BALTIMORE: (No. ST 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Clark

(a) RESIDENCE NO. 838 W. Ostend ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Junk man

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Jane ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed OCT 14 1929 OCT 14 1929 H. M. JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1929, to Oct. 11, 1929, that I last saw him alive on Oct. 11, 1929 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic Fatal

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist Path

(Signed) Warren H. McLane, M. D.

10-13, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Oct 14 1929
20 UNDERTAKER	ADDRESS
[illegible]	1364 W Cary

IMPORTANT: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50026

E 50026

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1085

CITY OF BALTIMORE: (No. Kennedy Hospital ST. 27-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mabel Miller.

(a) RESIDENCE NO. 2809 Halcyon ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles M. Miller

6 DATE OF BIRTH (month, day, and year) Feb. 22-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bentley Springs Md.

PARENTS

10 NAME OF FATHER James B. Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bentley Springs Md.

12 MAIDEN NAME OF MOTHER Dora Tenney.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14

Informant Chas. M. Miller

(Address) 2809 Halcyon Ave

Filed OCT 14 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Oct 12, 1929, that I last saw h alive on Oct 12, 1929 and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis cerebral of months.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Anemia and Septicemia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Autopsy

(Signed) C. W. Peck M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 15 1929.
20 UNDERTAKER	ADDRESS
Hartenstein Mortuary	3rd & Bice Sts.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50027

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50027

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. 16-68

CITY OF BALTIMORE: (No. 2741 Raynes Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jasmine W. Clements

(a) RESIDENCE NO. 2741 Raynes Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella M. Clements

6 DATE OF BIRTH (month, day, and year) Aug 19,

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Coat

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor.

(c) Name of employer

9 BIRTHPLACE (city or town) md
(State or country)

PARENTS

10 NAME OF FATHER Joshua Clements

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Grimes

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Clarence A Clements

(Address) 2741 Raynes Ave

Filed OCT 14 1929, 19 C. HAMPSON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug, 19 29, to Oct 11, 19 29,

that I last saw him alive on Oct 11, 19 29

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Uraemia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Sh. Wineing, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 14 1929
20 UNDERTAKER	ADDRESS
Ebenezer Elson	915 Eutaw St

IMPORTANT—Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Munger

E 50028 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50028

CERTIFICATE OF DEATH. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital (St.) 3-57 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Lena) Lena Munger

(a) RESIDENCE NO. 3666 Fern Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Mr. Munger

6 DATE OF BIRTH (month, day, and year) 12/4/87

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rochester N.Y.

PARENTS

10 NAME OF FATHER Theo. Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Fannie Terry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Hospital records. (Address)

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/5 1929 to 10/13 1929 that I last saw her alive on 10/13 1929 and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis following ruptured appendix

(duration) yrs. mos 1 0 ds.

CONTRIBUTORY (Secondary) Heart & chronic nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 10/9/29

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. H. Abramson M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Oct 16 1929
20 UNDERTAKER Edmondson	ADDRESS Westport

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S—2-29-28—L. F. S.—500 Bks.

E 50029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 50029

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Hanover St., 23-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer E. Clark

(a) RESIDENCE NO. 1700 Hanover ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: Fannie L. Clark

6 DATE OF BIRTH (month, day, and year): Dec. 14 1871

7 AGE — Years: 57 — Months: 9 — Days: 29 — If LESS than 1 day, hrs. or min.: 10 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store keeper

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Robt. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Amanda

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kentucky

11 Informant: Mrs Fannie L. Clark

(Address) 1700 Hanover St.

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 23rd, 1929 to Oct. 11, 1929, that I last saw him alive on Oct. 11, 1929 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabitis and aortic regurgitation of heart

(duration) yrs. 3 mos. 18 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) yrs. immediate mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of - - - -

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Henry Kleibel, M. D.

10/17 1929 (Address) 1224-1226 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Oct. 14, 1929

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50030

CERTIFICATE OF DEATH

99.002 E 50030

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Green

(a) RESIDENCE NO. Preston & Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 2 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
about	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER W. P. Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Christina Lothusen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Little Sisters of the Poor
(Address) Preston & Valley Sts

15 FILED OCT 14 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 13, 1929, that I last saw h— alive on Oct 12, 1929 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Bernard Wood M. D.

10/13 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	10/15 1929
20 UNDERTAKER Henry H. Myers & Son	ADDRESS 805 N. Calvert

CT 14 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spgn—2-29-28—L. F. S.—500 Blks.

Henry Perkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50031 — CERTIFICATE OF DEATH — 38 E 50031

1—PLACE OF DEATH Bacte City Hospt

CITY OF BALTIMORE: (No. Bacte Md ST., 26-07 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Perkins

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) Bacte City Hospt.

15 Filed G. HUMPSON JONES, M. D. Registrar

OCT 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-29

17

I HEREBY CERTIFY, That I attended deceased from 9-16, 1929, to 10-12, 1929, that I last saw him alive on 10-11, 1929 and that death occurred, on the date stated above, at 12.10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cerebro Spinal Lues & Cardio Renal Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Probable Clinical

(Signed) Henry G. Thomas M. D.

10/12 1929 (Address) Bacte City Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem	Oct 14 1929
20 UNDERTAKER	ADDRESS
A. V. Brown's Son	1054 W. Mond

REGISTRATION should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50032

Mrs Mary Hydock Zinkiewicz

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50032

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital Hydock ST. 25-32 WARD

2-FULL NAME Mrs Mary Zinkiewicz,

(a) RESIDENCE No. 2215 Sidney Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) June 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER William Aidukas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Krupstas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Charles Hydock

(Address) 2215 Sidney ave

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

By .....

OCT 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-10 1929, to 10-13 1929,

that I last saw her alive on 10-13 1929

and that death occurred, on the date stated above, at 10.30 P m

The CAUSE OF DEATH* was as follows:

Diabetes mellitus &
Pulmonary tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Draney, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel City Pa

DATE OF BURIAL Oct 14 19 9

UNDERTAKER Chas B. Kuchanska

ADDRESS 637 S Pac St

matter should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50033

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50033

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hosp's

REGISTERED NO. 38

CITY OF BALTIMORE: (No. Balto Md ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Goschboth

(a) RESIDENCE NO. 1731 E. Hoffman St. Lombard

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 027

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Goschboth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records Balto City Hosp's (Address)

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11-29

17 I HEREBY CERTIFY, That I attended deceased from 2-26, 1929, to 10-11, 1929, that I last saw h[illegible] alive on 10-11, 1929 and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Pleurisy - Effusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Harry Goldsmith M. D.

10/12, 1929 (Address) Balto City Hosp's

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 14-29.
20 UNDERTAKER	ADDRESS
Wendell & Lippold	3008 Eden

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50034

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50034

CERTIFICATE OF DEATH

46

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1906 N. Patterson Pk Ave ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Josephine Rosenberg

(a) RESIDENCE NO. 1906 N. Patterson Park ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Adams Rosenberg

6 DATE OF BIRTH (month, day, and year) July 7 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 03

(c) Name of employer

9 BIRTHPLACE (city or town) Cullo. Co.
(State or country)

PARENTS

10 NAME OF FATHER Edw. H. Winkler

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Lake

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Margie Hopkins

(Address) 1906 N. Patterson Pk Ave

15 Filed ....., 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1929

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Oct 13, 1929, that I last saw h.w alive on Oct 12, 1929 and that death occurred, on the date stated above, at 2 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

Cachexia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uterus Carcinoma

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Abm B Lennard M. D.

10/13, 1929 (Address) 718 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
E. L. Natural Cemetery	Oct 15 19
20 UNDERTAKER	ADDRESS
Kelly Bros Inc	1000 Wash Ave

IMPORTANT. See instructions on back of certificates.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE

Spec.—2-29-28—L. F. S.—600 Blks.

229 E 50035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 50035

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 21-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Warren

(a) RESIDENCE NO. 606 S. Eutaw ST., ST— WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/4/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md—

PARENTS

10 NAME OF FATHER Walter Warren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va—

12 MAIDEN NAME OF MOTHER Blanche Harrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N-Car—

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed Sept., 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-11-29

17

I HEREBY CERTIFY, That I attended deceased from Sept 28, 1929, to Oct-11, 1929, that I last saw h.r alive on Oct-11, 1929 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) ....yrs. ....mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys Exam

(Signed) E. C. Goodwin, M. D.

10/11, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	10-14 1929
20 UNDERTAKER	ADDRESS
Joseph L. Obrecht	4021 Mount St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50036

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 E 50036

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 19-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Collett

(a) RESIDENCE NO. 322 N. Caren ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Woman	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Widow

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Widow.

(b) General nature of Industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Solomon Hulemon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Rebecca Gilpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Records, Baltimore City (Address) Hospitals

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1929, to October 12, 1929, that I last saw her alive on October 12, 1929 and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam't Lab.

(Signed) Fred M. Drakeworth M. D.

Oct 13, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Oct. 14, 1929
20 UNDERTAKER Harry T. Witzke, 1531	ADDRESS W. Fayette St.

*OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 50037

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2036 W. Saratoga St. ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick C. Buhman

(a) RESIDENCE NO. 2036 W. Saratoga St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 11 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Buhman (nee Scott)

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1876.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Buhman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Clifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Bessie Buhman

(Address) 2036 W. Saratoga St.

15 Filed OCT 14 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 27, 19 29, to Oct 10, 19 29, that I last saw h alive on Oct 10, 19 29 and that death occurred, on the date stated above, at 10 00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Uraemia Toxaemia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dewey O McAvoy, M. D.

, 19 (Address) 700 N Paysan St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct. 14 19 29
20 UNDERTAKER Harry N. Witzke	ADDRESS 1538 Edmondson Ave

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-1929—Issue of 100,000.

E 50038

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50038

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4601 Liberty Hgts Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Smith

(a) RESIDENCE NO. 3627 Greenmount Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Smith

6 DATE OF BIRTH (month, day, and year) May 2 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Christian Science

(b) General nature of industry, business, or establishment in which employed (or employer) Practitioner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER William Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Chas. Reuter

(Address) 1113 Bonaparte Ave

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 12, 1929.

that I last saw him alive on Oct 12, 1929

and that death occurred, on the date stated above, at 8 25 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis.

(duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No. Date of ~

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jorge E. Shannon, M. D.

Oct 13 1929 (Address) 700 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Oct 15 1929

20 UNDERTAKER Chas E. Franck ADDRESS 802 Madison Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMILTON JONES, M. D.

OCT 14 1929

Form.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50039 ✓ E 50039

32

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1306 N. Stricker St ST., 15-23 WARD)

2—FULL NAME Agnes Sittte

(a) RESIDENCE NO. 1306 N Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arizona Sittte

6 DATE OF BIRTH (month, day, and year) Jan. 4, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jacob Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Catonsville, Md.

12 MAIDEN NAME OF MOTHER Joanna Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Woodlawn, Md

14 Informant Carrie Johnson

(Address) ~~same~~ 1306 N. Stricker St

15 Filed ....., 19 .....

OCT 14 1929 THOMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Oct 10, 1929, that I last saw her alive on Oct 10, 1929 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Cab

(Signed) H Marco Williams, M. D.

10-12-1929 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT Zion Cem	10-14-1929
20 UNDERTAKER Daniel Carter	ADDRESS 916 Ea ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

ROBERT I SHAVER

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50040

CERTIFICATE OF DEATH

117

E 50040

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 4-7 WARD)

2—FULL NAME Robert I Shaver

(a) RESIDENCE NO. Freeland Md ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 10 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER J E Shaver

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Akers

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant J. E. Shaver (Address) Freeland Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-29

17 I HEREBY CERTIFY, That I attended deceased from 10-10, 1929, to 10-12 1929, that I last saw him alive on 10-12, 1929 and that death occurred, on the date stated above, at 8 15 m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of 10/10/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) J Leyko, M. D.

10/12, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Freeland Md	10-15, 1929
20 UNDERTAKER E & B Harle 1156	ADDRESS West St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

11-4-1929 SAMPSON JONES M D

Spec.—1-10-21—M&T—1500 Blks.

35

E 59041

32 1897

E 5[redacted]41

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of [redacted] and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Astend ST. 11-29 WARD)

2-FULL NAME Elizabeth B. Bauman,

(a) RESIDENCE NO. 1307 Astend ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Bauman

6 DATE OF BIRTH (month, day, and year): May 20 1877

7 AGE — Years: 52 — Months: 4 — Days: 23 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jos Aulbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz Creamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William Bauman

(Address): 1307 Astend St

OCT [illegible] 19[illegible]

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929 to Oct 12, 1929.

that I last saw her alive on Oct 11, 1929.

and that death occurred, on the date stated above, at 3.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Diarrhoea.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Stanus M. D.

Oct 12, 1929 (Address) 1901 Griffis

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 10-15, 29

20 UNDERTAKER: Bernard C Hart

ADDRESS: 1000 Edmondson Ave

NOTICE—THIS CERTIFICATE, WHEN COMPLETED, BECOMES A PUBLIC RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 50042 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50042

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. 1124 N North Ave ST.; 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick L Mahr.

(Residence in Baltimore: No. 1124 N North Ave St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male.	White	Married

6-DATE OF BIRTH, Sept. 14th, (Month) (Day) 1867 (Year)

7-AGE. 62 yrs. 0 mos. 29 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Henry Mahr

11-BIRTHPLACE OF FATHER (State or Country) Balto Md.

12-MAIDEN NAME OF MOTHER Catherine Hayer

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie E Mahr

(Address) 1124 N North Ave

15- Filed OCT 14 1929, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 12 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 10 1929, to Oct 11 1929. that I saw him alive on Oct 11 1929. and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease with decompensation

(Duration) 10 yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 1 yrs. ...mos. ...ds.

(Signed) Joseph N Zeller M. D.

Oct 13, 1929 (Address) 701 Medical Arts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 10 17, 1929

20-UNDERTAKER Mrs Chas A G Rohde — ADDRESS 2327 Edmondson Ave

Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50043

CERTIFICATE OF DEATH

145-003

E 50043

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 4-96 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie McKay

(a) RESIDENCE NO. 708 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Fem.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15th 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
16	16	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Duncan McKay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Myrtle Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed OCT 14 1929, 19 Par ____ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11/29

17 I HEREBY CERTIFY, That I attended deceased from 9/20, 1929, to 10/11, 1929, that I last saw h[illegible] alive on 10/11, 1929 and that death occurred, on the date stated above, at 5 40 a. m.

The CAUSE OF DEATH* was as follows:

Pregnancy - Perturbation

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Pelvic Cellulitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 10/7/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. U. Lumpkin, M. D.

10/11, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

20 UNDERTAKER Robt. F. Turner

DATE OF BURIAL Oct 14 1929

ADDRESS W. Pratt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50044

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50044

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Normal Ave 26-39 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph F. Eder

(a) RESIDENCE NO. 126 N. Wolfe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Male	white	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17th 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER George Eder

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Mary R Krinzer

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto, Md

14 Informant Mrs Eder

(Address) 1615 Normal Ave

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 1929, to Oct 12 1929

that I last saw him alive on Oct 11 1929

and that death occurred, on the date stated above, at 9 A M. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Organic Heart Dis (duration)

1 yrs. mos. ds.
(duration)

18 Where was disease contracted if not at place of death? Own home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

12/13/29 (Signed) Fritz J Krinzer, M. D.

. 19 (Address) 1700 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 15 1929
20 UNDERTAKER Ralph Turner Inc	ADDRESS W. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 38 E 50045

CERTIFICATE OF DEATH

E 50045 REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 19-24 WARD)

2—FULL NAME Elva Little

(a) RESIDENCE NO. 337 S. Calhoun ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Charles Little

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant: Baltimore City Hospitals (Address) C. HAMPSON JONES, M. D.

15 Filed OCT 14 1929 Pol' ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 17, 1929

17 I HEREBY CERTIFY That I attended deceased from Sept. 16, 1929 to Oct 12, 1929 that I last saw h alive on Oct 12 1929 and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? .....

What test confirmed diagnosis? Clinical & Serological findings

(Signed) Harry Goodman M. D.

10/13/1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cathedral	10/16 1929
20 UNDERTAKER	ADDRESS
W. M. Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 50046

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3642 Hanover St. 25-75 WARD)

2-FULL NAME Mildred Elizabeth Coffin

(a) RESIDENCE No. 3642 Hanover St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Wh	single

5a If married, widowed or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 23 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
17	17	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George W. Coffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elizabeth Wietzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant George W Coffin

(Address) 3642 Hanover St.

15 Filed OCT 14 1929 19 C. HAMPSON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 12th 1929, to Oct 13th 1929.

that I last saw her alive on Oct 13th 1929

and that death occurred, on the date stated above, at 8.22 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

Endocarditis, Chronic.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthritis, Multiple.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Robert W Johnson M. D.

. 19 (Address) 3564 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	10/16/29
UNDERTAKER	**ADDRESS**
Wm Cook 1217	St Paul st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

8

E 50047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 50047

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 150 S. Hilton ST. 20-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME S. Henry Eckert

(a) RESIDENCE NO. 150 S Hilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of S. H. Eckert

6 DATE OF BIRTH (month, day, and year) May 19, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	21 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Gottlieb Eckert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mobley

(Address) 150 S. Hilton St

15 Filed 19 By C. HAMILTON JONES, M. D. Registrar

OCT 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-'29

17 I HEREBY CERTIFY, That I attended deceased from 10-8- 1929 to 10-12 1929 that I last saw him alive on 10-12 1929 and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No + Hemorrhage

What test confirmed diagnosis? Clinical Symptoms

(Signed) Amelia C. Lindt M. D.

10/12. 1929 (Address) 1717 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	10/15 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 E Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50048 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50048

8 90

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital. REGISTERED NO. 8-17

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hugh J. McCabe

(a) RESIDENCE NO. 1929 E North Ave ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie E McCabe

6 DATE OF BIRTH (month, day, and year) Apr 11, 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McCabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Minnie E McCabe

(Address) 1929 E North Ave

15 Filed ....., 19..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-9, 1929, to 10-11, 1929,

that I last saw him alive on 10-11, 1929

and that death occurred, on the date stated above, at 9 25 P m.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) 20+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Myocarditis

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

10/11, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	10/15 1929
UNDERTAKER J. W. Cook	ADDRESS 1217 E Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50049

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50049

CERTIFICATE OF DEATH

7H-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 Clifton Ave ST. 8-45 WARD)

2—FULL NAME Robert H. Magness

(a) RESIDENCE NO. 1639 Clifton Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 16 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jerome E. Magness

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Josephine Segerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Sarah C. Swaringen

(Address) 1639 Clifton Ave

Filed OCT 14 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1929, 19..., to Oct 12, 19 29

that I last saw him alive on Oct 11, 19 29

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Hemiplegia

(duration) 9 yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) T. S. Long, M. D.

10/13 1929 (Address) 6 E. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dear Park Cemetery	Oct. 14 1929
20 UNDERTAKER John Ellerd	ADDRESS 200 E Orleans St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 50050

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50050 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4600 Park Heights Ave St. 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Wells

(a) RESIDENCE NO. 4600 Park Heights Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~her~~ WIFE of Richard C Wells

6 DATE OF BIRTH (month, day, and year) June 28 1848

7 AGE: Years 81 Months 3 Days 15 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Wm Jamison

11 BIRTHPLACE OF FATHER (City or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Elenore Turvill

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mary Wells (Address) 4600 Park Heights Ave

OCT 14 1929

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929. Oct 13

17 I HEREBY CERTIFY, That I attended deceased from ....., 1923, to Oct 13, 1929.

that I last saw her alive on Oct 12, 1929.

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Coronè dilatation

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY Myocarditis (Secondary)

..... (duration) 6 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hayward, M. D.

Oct 14 1929. (Address) 1129 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Westminster Md	10-15- 1929
20 UNDERTAKER	ADDRESS
Edw C Tipton	Halfpstead Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50051

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50051

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 27-44

CITY OF BALTIMORE: (No. 2602 Gittons ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph. G. Schneider

(a) RESIDENCE NO. 2602 Gittons ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Margaret Schneider

6 DATE OF BIRTH (month, day, and year) Oct 18th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	11	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Sebastian Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Steiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Margaret Schneider

(Address) 2602 Gittons ave

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12-1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1928, to Oct 12, 1929

that I last saw h alive on Oct 12, 1929

and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum & X Ray

(Signed) Thos. F. Symes, M. D.

10/13/1929 (Address) 2618 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 16 1929
20 UNDERTAKER Glenny Steck Sons Inc.	ADDRESS 130, E Eager St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50052

CERTIFICATE OF DEATH

89 ✓ E 50052

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1900 Eulgrave Ave. ST., 27-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Chipman Carver

(a) RESIDENCE NO. 1900 Eulgrave Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Davison Carver

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer New Howard Hotel

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank H Carver.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Virginia Fairchild

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Frances D. Carver

(Address) 1900 Eulgrave Ave

15 Filed OCT 4 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Oct 11, 1929, that I last saw h.. alive on Oct 11, 1929 and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

I do not know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nothing Obtained (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A R Goodwin M. D.

(Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Oct. 14 1929
20 UNDERTAKER Wm Thickner Sons	ADDRESS North & Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Bks.

E 50053

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50053

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE; (No. Mt Hope Retreat ST. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Kenny Jackson

(a) RESIDENCE NO. 2152 Penna ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. ~ mos. 2 ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Sept 26 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Co

(c) Name of employer Unk

9 BIRTHPLACE (city or town) (State or country) Mercer Penna

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Mt Hope Retreat (Address) Mt Hope Retreat

15 Filed OCT 14 1929, 19 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Oct 14, 1929, that I last saw him alive on Oct 13, 1929 and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Edema.
(Chr. Alcoholism)

(duration) yrs. ~ mos. 5 ds.

CONTRIBUTORY (Secondary) Alcoholism (duration) 15 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ~

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisburg, Penna	Oct 14, 1929

20 UNDERTAKER H. W. Mears & Son ADDRESS 805 N. Calvert St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50054 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50054

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 114 S. Broadway (ST.) B-4 (WARD)

2-FULL NAME Henry C. Winebrenner

(a) RESIDENCE NO. 1114 S. Broadway ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C Winebrenner

6 DATE OF BIRTH (month, day, and year) July 5, 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oyster + Fruit Packer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hanover Pennsylvania

PARENTS

10 NAME OF FATHER: Henry C Winebrenner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hanover Penn

12 MAIDEN NAME OF MOTHER: Sabra P Forney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hanover Penn

14 Informant: Emma C Winebrenner

(Address): 114 S Broadway

15 Filed OCT 14 1929. 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929, to Oct 13, 1929, that I last saw him alive on Oct 13, 1929, and that death occurred, on the date stated above, at 11.40 m.

The CAUSE OF DEATH* was as follows:

Bronchitis

Myocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of.

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) E. Gill Hall M. D.

Oct 17, 1929 (Address) 1631 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hanover Pens — DATE OF BURIAL: Oct 17 1929

UNDERTAKER: Louis Heemann — ADDRESS: 32 S Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50055

CERTIFICATE OF DEATH.

100-001

E 50055

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 S. Stiles ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guy Foltitsky

(a) RESIDENCE NO. 1524 N. Wolfe ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1929

7 AGE — Years: — Months: — Days: 2 1/2 — If LESS than 1 day, hrs. or ... min.: 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ....

(b) General nature of industry, business, or establishment in which employed (or employer): ....

(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Michael Foltitsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canada

12 MAIDEN NAME OF MOTHER: Catherine Kowalick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S.

14 Informant: R. G. Douglas.

(Address) Johns Hopkins Hospital

OCT 14 1929

Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-10, 1929 to 10-13, 1929.

that I last saw her alive on 10-13, 1929

and that death occurred, on the date stated above, at 5.00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? ....

(Signed) R. G. Douglas M. D.

, 19..... (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Oct 14 1929

20 UNDERTAKER: John M Weber — ADDRESS: 401 N Charles

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50056

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 50056

CERTIFICATE OF DEATH

159-002

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2840 O. Donnell ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leon P. Serenez

(a) RESIDENCE NO. 2840 O. Donnell ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 21 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	4	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Serenez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Stephanie Kalinowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Serenez
(Address) 2840 O. Donnell

15 Filed OCT 14 1929 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12. 29

17 I HEREBY CERTIFY, That I attended deceased from July 5 1929 to Oct 12 1929

that I last saw her alive on Oct 12 1929

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Trouble

5
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William P. Lowe M. D.

Oct 14, 1929 (Address) 806 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	10/15 1929
20 UNDERTAKER	ADDRESS
W. J. S. Fitzgerald	1020 S. Kenwood Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50057 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50057

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (NO. 7-5-12 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mgt. Hague

(a) RESIDENCE NO. Titusville Fla ST. Marguerite WARD Hague

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 dy. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas E. Hague

6 DATE OF BIRTH (month, day, and year): Sept 26 1895

7 AGE: Years 34 Months — Days 18 If LESS than 1 day, ... hrs or ..... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER: Wm A. Norwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Sarah Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Florida

14 Informant: Thos A. Hague

(Address) Titusville, Fla

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-13- 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-29, 1929, to 10-13, 1929

that I last saw her alive on 10-13, 1929

and that death occurred, on the date stated above, at 8.40 p m

The CAUSE OF DEATH* was as follows: Carcinoma of abdomen (apparent)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Metastasis to brain

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Robert L. Smellie, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Titusville, Florida | DATE OF BURIAL: Oct 17 1929

20 UNDERTAKER: J. D. Mayfield | ADDRESS: 15 W Church St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

E 50058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50058

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Ramsey ST. 70-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Hensler

(a) RESIDENCE NO. 2005 Ramsey ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie J. Hensler

6 DATE OF BIRTH (month, day, and year): Oct 2nd 1879

7 AGE: Years 50 | Months = | Days 10 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): Lochman Hill Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Fletcher Hensler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Essenwein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Elsie J. Hensler
(Address): 2005 Ramsey St

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

T 141029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 7 1929, to Oct 13 1929, that I last saw h[e] alive on Oct 11 1929, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Colon

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eyth M. Montgomery M. D.

19 (Address) 3330 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Oct 15th 1929

UNDERTAKER: H. Wisgant — ADDRESS: 1515 Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50059 ✓ E 50059

CERTIFICATE OF DEATH

161-001

1—PLACE OF DEATH 217 N. Bond Street — REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace Ernestine Young

(a) RESIDENCE NO. 217 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	cd	

a If married, widowed, or divorced 4 HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10-3-29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Howe Brown

11 BIRTHPLACE OF FATHER (city or town) Mayfield (State or country) St. Mary's

12 MAIDEN NAME OF MOTHER Grace Young

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country) St. Mary's

14 Informant Father (Address) 217 N Bond St

15 Filed OCT 14 1929 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-29

17

I HEREBY CERTIFY, That I attended deceased from 10-3, 19 29, to 10-12, 19 29

that I last saw h[illegible] alive on 10-12 19 29

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity
Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. B. Butler M. D.

, 19 (Address) 425 N. Curtis Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS OCT 14 1929

OF DEATH in plain terms, so that it may be properly c
important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50060

CERTIFICATE OF DEATH

161-001 E 50060

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1529 N Montford Ave St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Foetus Matthews

(a) RESIDENCE NO. 1529 N Montford Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Foetus

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — IF LESS than 1 day ..... hrs. or 30 min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Foetus

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER John P. Matthews

11 BIRTHPLACE OF FATHER (City or town)

(State or country) New York, Pa

12 MAIDEN NAME OF MOTHER Mary A. Chilcote

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto, Md

14 Informant Mary A Matthews

(Address) 1529 N. Montford Ave

15 Filed 6/4 1929 C. HAMPSON JONES, Registrar M. D.

By CKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Oct. 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 19 29, to Oct 12, 19 29,

that I last saw h[illegible] alive on Oct 12, 19 29,

and that death occurred, on the data stated above, at 11:40 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank H Mont, M. D.

. 19 (Address) 405 Tall's Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — Date of Burial: Oct 14 1929

20 UNDERTAKER — ADDRESS

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ✓ E 50061

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

2—FULL NAME Randall D. Franke

(a) RESIDENCE NO. 1112 Ashland Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooking 21

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Jennie Norwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL JOHNS HOPKINS HOSPITAL

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11-1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1929 to Oct. 11, 1929

that I last saw h.. alive on Oct 11, 1929

and that death occurred, on the date stated above, at 10 00 a- m.

The CAUSE OF DEATH* was as follows:

aneurysm of aorta

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Rud M Ellsworth M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL.

DATE OF BURIAL

19

20 UNDERTAKER Commissioner Health

ADDRESS OCT 14 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50062 ~~E 50276~~ 21 VE 50062

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jerome Amos

(a) RESIDENCE NO. 3230 Barclay Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-16-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Conrad

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Aurelia Steward

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 10 4 1929 C. HAMPSON JONES, M. D.
(Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 10, 1929, that I last saw him alive on Oct 10, 1929, and that death occurred, on the date stated above, at 4:25 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clin Phys Exam

(Signed) J. C. Goodwin, M. D.

10/10, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS OCT 14 1929

C. Hampson Jones, M. D. Commissioner Health

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

22E 50063

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50063

CERTIFICATE OF DEATH

159-002

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. 19-27 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Gambrill

(a) RESIDENCE NO. 1712 4 - Sexughia ST., H - WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER Cashes Gambrill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md —

12 MAIDEN NAME OF MOTHER Louise Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md —

14 Informant: Reads —
(Address) JOHNS HOPKINS HOSPITAL

15 OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 9 - 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 5 1929 to Oct 9 1929

that I last saw h~~e~~ alive on Oct 9 1929

and that death occurred, on the date stated above, at 12 25 P. m.

The CAUSE OF DEATH* was as follows:

Congenital cardiac anomaly

(1 Life)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. M. Bickford Jr., M. D.

19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

OCT 14 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 50064 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50064

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Greenmeldar ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude G. Milburn

(a) RESIDENCE NO. 503 Greenmeldar ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas L Milburn

6 DATE OF BIRTH (month, day, and year) May 29, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier in

(b) General nature of industry, business, or establishment in which employed (or employer) Movie - Place

(c) Name of employer Ben Morrison

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Allen

11 BIRTHPLACE OF FATHER (city or town) Charlottesville
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary E. Bauer

13 BIRTHPLACE OF MOTHER (city or town) Nelson Co
(State or country) Virginia

14 Informant Mary E. Allen
(Address) 503 Greenmeldar

15 DEC 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1929

17

I HEREBY CERTIFY, That I attended deceased from 9/17, 1929, to 10/11, 1929, that I last saw her alive on 10/11, 1929, and that death occurred, on the date stated above, at 7 O. m.

The CAUSE OF DEATH* was as follows:

Chronic

Endocarditis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) David Franklin, M. D.

10/15/29 (Address) 122 W Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peter's Cemetery	Oct 15, 1929
20 UNDERTAKER	ADDRESS 322
Mrs Kate R. Williams	1 Schroeder Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

33 ✓ E 50065

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Victoria Gaskins

(a) RESIDENCE NO. 1020 W. Saratoga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Louis Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lottie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address): Balto. City Hospitals

15 Filed: 1 4 1929 By: C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1929 to Oct. 9, 1929

that I last saw her alive on Oct. 9, 1929

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis (suspected Tuberculous)

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) Anemia, secondary

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 9-5-29? (over)

Was there an autopsy? Yes

What test confirmed diagnosis? Post Operation Autopsy

(Signed) Harvey M. McClean, M. D.

10-14, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct. 14 1929
20 UNDERTAKER: Mrs. Catherine Williams	ADDRESS 322 N. Schroeder

Property classified. Exact statement of OCCUPATION necessary for proper filing of DEATH certificates. In plain terms, so that it may be understood. See instructions on back of certificate. important.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50066

CERTIFICATE OF DEATH.

+3 ✓ E 50066

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 Wheeler Ave St. 20-69 Ward

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pasquale Gugliuzza

(a) RESIDENCE NO. 19 Wheeler Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wite	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Teresa Cangelozzi

6 DATE OF BIRTH (month, day, and year) December 4 1882

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
46	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer) 019

(c) Name of employer C

9 BIRTHPLACE (city or town) Cefalu

(State or country) Palermo Italy

PARENTS

10 NAME OF FATHER Giuseppe Gugliuzza

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Marianna

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy.

14 Informant (Address) Pasquale Cammerata 2436 W. Baltimore St.

15 Filed 10 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1929

17

I HEREBY CERTIFY, That I attended deceased from 4-4- 1929, to 10-13- 1929.

that I last saw him alive on 10-11- 1929

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Tongue metastasis in lymph-glands

(duration) 2 abt yrs. mos. ds.

CONTRIBUTORY (Secondary) manition -

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of See Dr. Blood's

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel C. Ford M. D.

10-14 1929 (Address) Medical Arts Bld'g.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial 10/15 1929

20 UNDERTAKER: George J. Ruth — ADDRESS 1730 Linwood Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50067 | E 50067

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 S Eaton St. 16-37 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lydia V. Cushing

(a) RESIDENCE NO. 418 S Eaton St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph H. Cushing

6 DATE OF BIRTH (month, day, and year) April 7 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER Emanuel Yingling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E Bellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph Cushing

(Address) 418 S Eaton St

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/26/29, 19..., to 10/13, 19 29, that I last saw h alive on 10/12, 19 29 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
myocarditis

(duration) 1 yrs. — mos. — da.

CONTRIBUTORY (Secondary) Acute Cardiac dilation

(duration) — yrs. — mos. —

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What tests confirmed diagnosis? —

(Signed) [illegible] M. D.

(Address) 33 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolkburg Methodist Cem.	Oct 16 1929

20 UNDERTAKER — ADDRESS

Martin W. B. Disque & Son 32 S Conkling St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 50068

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland Gen. Hospital

CITY OF BALTIMORE: (No. 28-6½ St. WARD)

REGISTERED NO. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. Hugh P McCormick

(a) RESIDENCE NO. 3704 Eldorado Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23, 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister of

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louden Co., Virginia

PARENTS

10 NAME OF FATHER Robert B McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Raynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital record
(Address)

15 T 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/13, 1929, to 10/14, 1929,

that I last saw him alive on 10/13, 1929,

and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) — yrs. — mos 0 ds.

CONTRIBUTORY (Secondary) Coronary thrombosis

(duration) 6 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Jno A Hampson, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL Oct 15, 29

20 UNDERTAKER John O Mitchell Sons ADDRESS 19 E Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50069

CERTIFICATE OF DEATH

E 50065

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hosp St. 25-12 (Ward)

2-FULL NAME Frank Roland Leatherbury

(a) RESIDENCE NO. 34-Frost St (Lansdowne) St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Apr-26-1920

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	9	5	17	

8 OCCUPATION OF DEACESED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Frank Roland Leatherbury

11 BIRTHPLACE OF FATHER (city or town) Wals
(State or country) Md

12 MAIDEN NAME OF MOTHER Alma M. Stallings

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Frank R. Leatherbury
(Address) 34 Frost St. Lansdowne

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar
OCT 14 1929 By ....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquest find that said deceased came to his death (Inquest, autopsy or inquiry)
on the day stated above.

The CAUSE OF DEATH* was as follows:
Meningitis - secondary to puncture wound of R orbit
run down by auto while skating (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fract - Traumatic of frontal bone (R. orbit) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hammond Prep Sch
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) H. J. Frame M. D.
10/14 1929 (Address) 2939 N. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Oct 15th 1929
20 UNDERTAKER	ADDRESS
H. Hilgert	1150 N. Bond St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 50070

1—PLACE OF DEATH

REGISTERED NO. 28-63

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank J. Russell

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD Jersey City N. J.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 7 mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec 28/1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Formerly Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Bayonne New Jersey

PARENTS

10 NAME OF FATHER: Elijah Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brooklyn New York

12 MAIDEN NAME OF MOTHER: Ellen Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Mt Hope Records

(Address): Mt Hope Retreat

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 13 1921, to Dec 13 1929, that I last saw him alive on Dec 13 1929, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Dementia Praecox

(duration) 15 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Bayonne N. J.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jersey City N. J.	Dec 16 1929.
20 UNDERTAKER	ADDRESS
Edward W. Lowe & Co	Balto

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50071

CERTIFICATE OF DEATH

129 E 50071

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2315 E. Madison ST., 7-12 WARD)

2—FULL NAME George Smith

(a) RESIDENCE NO. 2315 Madison ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Smith

6 DATE OF BIRTH (month, day, and year) July 4th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or partiruiar kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Louis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie B. Smith

(Address) 2315 Madison St.

15 Filed OCT 14 1929 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-29

17

I HEREBY CERTIFY, That I attended deceased from 9-29-29, 19..., to 10-11-29, 19...

that I last saw h... alive on 10-11-29

and that death ocrurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis, Hypertension

Arteriosclerosis

Cerebral Hemorrhage 3 days

CONTRIBUTORY (Secondary) Duodenal Ulcer 2 yrs. 1 mos. 11 ds.
(duration)

18 Where was disease contrarted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Hopkins M.D.

10-14-29 (Address) 800 N. Wolfe

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 15, 1929
20 UNDERTAKER	ADDRESS
Mrs. E. Miller & Son	2334 Eutaw Pl.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50072

CERTIFICATE OF DEATH

E 50072

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) South Baltimore General Hospital ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Marion Conway

(a) RESIDENCE NO. 1523 William ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Conway

6 DATE OF BIRTH (month, day, and year) Feb. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Travers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louise Tanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank Conway

(Address) 1523 William St

15 Filed 10 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13-29

17 I HEREBY CERTIFY, That I attended deceased from 10-13, 1929, to 10-13, 1929 that I last saw her alive on 10-13, 1929 and that death occurred, on the date stated above, at 8.18 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic nephritis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Typical findings

(Signed) Joseph Eberkaitis M. D.

19 (Address) South Baltimore Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eden Hillbern	Oct 16 1929

20 UNDERTAKER	ADDRESS
C. Howard Evans	38 E. Fort Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 50073

CERTIFICATE OF DEATH

E 50073

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Hospitals Ward) 3

2-FULL NAME John Konopacki (Jr)

(a) RESIDENCE NO. 930 S. Kenwood Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8- 1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF ~~Blazey~~ John Konopacki

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Kundeguda Janak

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant ~~Blazey~~ Konopacki
(Address) 960 S. Kenwood Ave

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

OCT 15 1929 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

10/14. 1929. (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Oct. 15 1929
20 UNDERTAKER	ADDRESS
Stephen J. Falkowski Inc	1002 S. Kenwood Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 50074 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital 13-54 (ST.) (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Goodman

(a) RESIDENCE NO. 2440 (ST.) Lakenen ave (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Goodman

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE — Years: 80 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Goldstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dinkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Laws
(Address) 1439 E. Baltimore

15 Filed 10 15 1929 . C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10 - 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Oct 16, 1929, that I last saw her alive on Oct 13, 1929, and that death occurred, on the date stated above, at 6:40 A.m.

The CAUSE OF DEATH* was as follows:

1st Bronchopneumonia

Senile psychosis (chron)

(duration) yrs. mos. 2 mos

CONTRIBUTORY (Secondary) → Fracture left femur

(duration) yrs. mos. 4 mos

18 Where was disease contracted if not at place of death? Pneumonia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X-Ray

(Signed) Benj H Klotz, M. D.

10/14, 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehren Southern Lay — DATE OF BURIAL: 10/15 1929

20 UNDERTAKER: Jack Laws 1439 E Balt St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 50075

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50075

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. W-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Goldner

(a) RESIDENCE NO. Sinai Hospital ST., 1719 E Baltimore WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Goldie Goldner

6 DATE OF BIRTH (month, day, and year) 8-4-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Ans

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hirsh Goldner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Emma Eberlich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Goldie Goldner

(Address) 1719 E. Balto St

15 Filed OCT 15 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1929. to Oct. 13, 1929.

that I last saw him alive on Oct 13, 1929.

and that death occurred, on the date stated above, at 10.35 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hypertension

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel J. Hantman M. D.

1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 10/15 1929

20 UNDERTAKER Jack Levis — ADDRESS 1709 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50076 HEALTH DEPARTMENT—CITY OF BALTIMORE x 49 E 50076

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2—FULL NAME Edward Noetzli

(a) RESIDENCE NO. 618 New York ST., ave WARD 4-4 - Wash - H-C-
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S- China

PARENTS

10 NAME OF FATHER Ed- Noetzli

11 BIRTHPLACE OF FATHER (city or town) Switz - (State or country)

12 MAIDEN NAME OF MOTHER Mc Munn

13 BIRTHPLACE OF MOTHER (city or town) Scr - (State or country)

14 Informant Friends -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-14-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 14, 1929, that I last saw h.e.r. alive on Oct 14, 1929, and that death occurred, on the date stated above, at 2-15 P. m.

The CAUSE OF DEATH* was as follows:

Neoplasm of lung - probably carcinoma.

probably about 6 months.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema 5 hours
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & clinical examination.

(Signed) Alexander Brunn, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington DC	10/15 1929
20 UNDERTAKER Robert Brook & Son	ADDRESS 1138 Eutaw

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 ✓ E 50077

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 510 Scott St. ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Gorrick

(a) RESIDENCE NO. 510 Scott St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Luke Gorrick

6 DATE OF BIRTH (month, day, and year) Dec. 24th 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Martin Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Egan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Annie Morheser

(Address) 510 Scott St.

15 Filed OCT 15 1929, 19 C. HAMPSON JONES, M. D. Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from October 9th 19 29, to October 12, 19 29, that I last saw her alive on October 12, 19 29 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 10 Yrs.

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw Nevola, M. D.

, 19 (Address) 24 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 16th 1929
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-002

E 50078

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 855 Woodward ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Sanahan.

(a) RESIDENCE NO. 855 Woodward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 5th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Denis J. Sanahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Florence Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant Denis J. Sanahan

(Address) 855 Woodward St.

15 Filed ..... 19 .....

By ..... Registrar

C. HAMILTON COOPER, M. D.

OCT 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from October 5 1929 to October 14 1929

that I last saw h alive on October 14th 1929

and that death occurred, on the date stated above, at 11.00 A.m.

The CAUSE OF DEATH* was as follows:

(Probable) Patent Foramen Ovale

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Non Aeration of Blood

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Young M. D.

(Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 15th 1929
20 UNDERTAKER	ADDRESS
John F. Cowan & Son.	901 Holland St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Amy T. Showell

E 50079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50079

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 805 N. Dallas ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amy T. Showell

(a) RESIDENCE NO. 805 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Showell

6 DATE OF BIRTH (month, day, and year) Apr. 16-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Georgia M. Cranston

(Address) 1520 Druid Elderry St.

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Oct. 13, 1929.

that I last saw her alive on Oct. 13 1929

and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

(1) Chr. Myocarditis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Calvin B. Le Compte, M. D.

, 19 (Address) 814 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashley Cemetery	Oct. 16 1929
UNDERTAKER Chas. H. Johnson	ADDRESS 416 N. Carolina St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 50080

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 524 S. Belnord Ave. ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jakob Taraszewski also Tarasuik

(a) RESIDENCE NO. 524 S. Belnord Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Taraszewski

6 DATE OF BIRTH (month, day, and year) Unk 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B.&.O

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Jan Taraszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Taraszwski

(Address) 524 S. Belnord Ave

FILED OCT 15 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 19 29, to Oct. 13, 19 29, that I last saw him alive on Oct. 13, 19 29 and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Lactica

one year (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-ray Laboratory & Physical

(Signed) N. Alpiki M. D.

10/14, 1929 (Address) 2430 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 16 29 19
20 UNDERTAKER	ADDRESS
F. W. Ozarowski 1930	Eastern Av.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50081

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2800 Mayfield ave (WARD) 8-45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter Petherson

(a) RESIDENCE NO. 2800 Mayfield ST. ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Peterson

6 DATE OF BIRTH (month, day, and year) Feb. 22 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Capitain

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10 NAME OF FATHER Peter H. Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant Mrs. Catherine Peterson

(Address) 2800 Mayfield ave.

15 Filed OCT 15 1929 19 C. HARRISON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1 1929, to Oct 13 1929, that I last saw h alive on Oct 13 1929 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

t8 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J Guerney, M. D.

Oct 14. 1929 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Cem'ty	Oct. 16, 1929
20 UNDERTAKER John A Moran	ADDRESS 3000 E. Balto St

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50082

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50082

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 5-8 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt Briscoe

(a) RESIDENCE NO. 1301 Orleans St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	col	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) O/C

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co Md.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Provident Hosp (Address)

15 Filed [illegible], 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-11, 1929, to 10-13, 1929, that I last saw h alive on 10-13 1929, and that death occurred, on the date stated above, at 6 A.M. The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benjamin Baer, M. D.

10/16, 1929 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	10-15 1929

20 UNDERTAKER ADDRESS

Dennis Easton 916

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

OCT 15 1929 HAMPSON JONES, M. D.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 50083 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50083

1-PLACE OF DEATH 1230 W Lombard St. REGISTERED NO.

CITY OF BALTIMORE: (No 18-26 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Murphy

(a) RESIDENCE. No. 1230 W Lombard ST.. WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Murphy

6 DATE OF BIRTH (month, day, and year): Feb 25 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: William Murphy
(Address) 1230 W Lombard St

15 Filed ..... 19 ..... CHAMPION JONES, M. D.
Registrar.
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1929, to Oct. 13, 1929, that I last saw h alive on Oct. 13, 1929, and that death occurred, on the date stated above, at 8 00 P. m.

The CAUSE OF DEATH* was as follows:

Malignant neoplasm left lung with metastasis in right lung

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Bronchoscopic

(Signed) W. H. Triplett, M. D.

19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 16 19 29
20 UNDERTAKER	ADDRESS
John F Dillon	220 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Katie Buchta

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50034

CERTIFICATE OF DEATH

E 50034

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1713 E. Oliver St., 8-17 Ward)

2-FULL NAME Katie Buchta

(a) RESIDENCE NO. 1713 E. Oliver St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George F. Buchta

6 DATE OF BIRTH (month, day, and year) Feb 2/1863

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	01	0	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jacob Uhl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Fink

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Wehrman
(Address) 1353 N. Collington Av.

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated Ventral Hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

10/15/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct. 16 1929
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons Inc	1301 E Eager

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50985

16-002

E 50085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital. St. 3-5 Ward)

2-FULL NAME Pauline De Angelo.

(a) RESIDENCE NO. 911 Stiles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) November 5, 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	11	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Anthony De Angelo.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Jennie Truninia.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Boston Mass.

14 Informant Anthony De Angelo. (father)
(Address) 911 Stiles St.

15 Filed OCT 15 1929 H. HAMPSON JONES, M. D. Registrar

Dep

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dysentery.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 911 Stiles St.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

10/14/29 (Address) 1015 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 15 1929
20 UNDERTAKER	ADDRESS
Wendell J. Lippold	West Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 50086

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50086

CERTIFICATE OF DEATH.

49 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Robinson

(a) RESIDENCE NO. 1917 Bentalou ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Fannie

6 DATE OF BIRTH (month, day, and year): Dec 1856

7 AGE: Years 73; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Max Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Ethel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs Robinson

(Address): 1912 N Bentalou St

15 Filed OCT 15 1929 C. HAMPSON JONES, M. D. REGISTRAR OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-14 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-7- 1929 to 10-14 1929

that I last saw him alive on 10-14-29 1929

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the head of the pancreas

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. myocarditis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) A. A. Eibor M. D.

10/14 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave

DATE OF BURIAL: Oct 15 29

UNDERTAKER: Jos Levinson & Bro

ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 50087

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Augusta Ave. WARD) 20-10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Fredk Gauss.

(a) RESIDENCE NO. 24 Augusta Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Eva Katherine Gauss.

6 DATE OF BIRTH (month, day, and year) August 17 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81.	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Jacob Gauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eva Katherine Gauss (Address) 24 Augusta Ave

15 Filed OCT 15 1929 C. HAMPSON JONES, M. D. By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/12 1929

17

I HEREBY CERTIFY, That I attended deceased from July 1 1929 to Oct 13 1929, that I last saw him alive on Oct 12 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Henry D Graham, M. D.

10/13 1929 (Address) 24 Augusta Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon

DATE OF BURIAL Oct 16 1929

UNDERTAKER Samuel Leyton

ADDRESS 1600 Or North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50088 HEALTH DEPARTMENT—CITY OF BALTIMORE. E 50088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2028 E. Pratt ST., 2-d WARD)

2-FULL NAME Infant Brown,
2028 E. Pratt

(a) RESIDENCE NO. 2028 E. Pratt ST., 2 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 16 2/

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Wm Brown

11 BIRTHPLACE OF FATHER (city or town) Ky. state
(State or country)

12 MAIDEN NAME OF MOTHER Lilian Zadel

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John Wm Brown
(Address) 2028 E. Pratt St.

15 Filed OCT 15 1929 C. HAMPSON JONES, M. D. Registrar
By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1929 to Oct. 14, 1929 that I last saw him alive on Oct. 14, 1929 and that death occurred, on the date stated above, at 11:15 P. M.

The CAUSE OF DEATH* was as follows:

Asphyxiation at birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Bruce Feingler M. D.

10/15, 1929 (Address) 2028 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Lawn Cemetery	Oct 16 1929
20 UNDERTAKER Kelly & Geiler Inc	ADDRESS 408 S. Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-29-28 1-5 500 Blks.

E 50089

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50089

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1223 Chatahamst WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Bell

(a) RESIDENCE NO. 1223 Chatahamst. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anderson Bell

6 DATE OF BIRTH (month, day, and year) Oct 4, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Green Bay
(State or country) Va

PARENTS

10 NAME OF FATHER Jack Reed

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

t4 Informant Mollie Scott
(Address) 1223 Chatahamst

t5 Filed OCT 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 19 29, to Oct 13, 19 29, that I last saw h.. alive on Oct 12, 19 29 and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertrophic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertension and Uremia

(duration) yrs. 6 mos. ds.

t8 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. L. Brown, M. D.

t9 Oct 14 29 (Address) 1724 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenbay Va	Oct. 15, t9 29
UNDERTAKER Thos. F. Elliott	ADDRESS 325 Ashland Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50090

CERTIFICATE OF DEATH

90 ✓ E 50090

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 W Northern 15-21 ST. WARD)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Schumacher

(a) RESIDENCE NO. 1639 W. Northern WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Schumacher

6 DATE OF BIRTH (month, day, and year) Dec 29 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self Baltimore Md

9 BIRTHPLACE (city or town) (State or country) " "

PARENTS

10 NAME OF FATHER Reinhard Schumacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy McDaid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Emma Schumacher

(Address) 1639 N Northern

15 Filed OCT 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13-29

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Oct 13, 1929, that I last saw h/ alive on Oct 13, 1929 and that death occurred, on the date stated above, at 11.50 m.

The CAUSE OF DEATH* was as follows:

Cardio - Vascular

(duration) 4 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual Typical Sx

(Signed) H. J. Doub, M. D.

Oct 14. 1929 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 16 1929
20 UNDERTAKER	ADDRESS
H. J. Deuchert's Sons	North Ave

Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50091

E 50091

74-081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3241 Phelps Lane St. 30-70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Fetsch

(a) RESIDENCE NO. 3241 Phelps Lane. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Fetsch.

6 DATE OF BIRTH (month, day, and year) Sept 4-1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76	1	10.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. gs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Valentine Fetsch

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Alsace Lorraine.

12 MAIDEN NAME OF MOTHER Barbara Selenger

13 BIRTHPLACE OF MOTHER (city or town) Litzelstein

(State or country) Germany.

14 Informant Lenora Vogel

(Address) 3241 Phelps Lane.

Filed OCT 15 1929 19 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14-1929.

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1929, to October 14, 1929; that I last saw h~~im~~ alive on October 14, 1929, and that death occurred, on the date stated above, at 12:10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Kuland, M. D.

10-14 1929 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem Date of Burial Oct 16 19 29

20 UNDERTAKER Wm J Pickner Sons ADDRESS W. & P

Do not use abbreviations. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50092 ✓

E 50092

CERTIFICATE OF DEATH.

122-002

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 8-4 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gernhart

(a) RESIDENCE NO. 1723 Cliftview Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Gernhart

6 DATE OF BIRTH (month, day, and year) July 24, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Andrew Gernhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Zeitler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record

(Address) E. HAMPDEN-JONES, M.

15 Filed OCT 15 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/13 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/12 .1929. to 10/13 .1929.

that I last saw him alive on 10/13 .1929.

and that death occurred, on the date stated above, at 1145 P m.

The CAUSE OF DEATH* was as follows:

Hepatic cirhosis (portal).

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Rt inguinal hernia acute intestinal obstructions

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakleaves Cemetery	Oct 17 1929

20 UNDERTAKER Wm Cook 1217 ADDRESS St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 50093

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 E. Lafayette Ave. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel W. Taylor Sr.

(a) RESIDENCE NO. 2018 E. Lafayette Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E. Taylor

6 DATE OF BIRTH (month, day, and year) Sept. 26-1852.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	77	-	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt. Savage, Md

PARENTS

10 NAME OF FATHER George E. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary V. Burgess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Samuel W. Taylor, Jr.

(Address) 1109 Rutland Ave

15 Date CT 15 1929 C. HAMPSON JONES, By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1929 to Oct 14, 1929, that I last saw him alive on Oct 13, 1929 and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher M. D.

10/15 1929 (Address) 1823 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Cemetery	Oct 16 1929
20 UNDERTAKER M. D. George W. Zirkle	ADDRESS 1737 E. Eager St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50094

CERTIFICATE OF DEATH

46

E 50094

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. Union Memorial Hospital, St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Elizabeth Bregenzer

(a) RESIDENCE NO. 30 E. St. Paul ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A Bregenzer

6 DATE OF BIRTH (month, day, and year) Nov 25, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Klein Smith

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Yager

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Self

(Address)

Filed OCT 15 1929, 19 W. HAMPSON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929, to Oct 15, 1929, that I last saw her alive on Oct 15, 1929, and that death occurred, on the date stated above, at 4.10 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary, right.
(Mass in lower abdomen)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchio Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical course

(Signed) James L. Fox, M. D.

10/15 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 17, 1929
20 UNDERTAKER Joseph L Cook	ADDRESS 1005 West Baltimore St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50095

E 50095

CERTIFICATE OF DEATH. No. 122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 Forrest ST. 16-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice J. M. Purnode

(a) RESIDENCE NO. 1012 Forrest ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 11± yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Frances Purnode

6 DATE OF BIRTH (month, day, and year) Oct. 31 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) General.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Belgium.

PARENTS

10 NAME OF FATHER Jean Purnode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Belgium.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Belgium.

14 Informant Carrie Frances Purnode (Wife)

(Address) 1012 W. Hamilton St. C. HAMILTON JONES, M.

15 Filed OCT 15 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 13 - 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1929 to Oct. 13, 1929.

that I last saw him alive on 10 - 11 - 1929

and that death occurred on the date stated above, at 2 00 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Chr. Alcoholism

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence.

(Signed) Geo. B. Dyhert, M. D.

10/13 29 (Address) 2902 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral cemetery

DATE OF BURIAL Oct. 13 1929

20 UNDERTAKER Adolph Hook

ADDRESS 1003 West Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50096

CERTIFICATE OF DEATH

117

E 50096

1—PLACE OF DEATH St Joseph Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 8-17 ST., (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Heiderich

(a) RESIDENCE NO. 2004 E Lanvale ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Heiderich

6 DATE OF BIRTH (month, day, and year) Feb 21-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER John Connolly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellenora Kennedy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Louis Heiderich

(Address) 2004 E Lanvale st

Filed 1929 .19 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 14, 1929, that I last saw h.. alive on Oct 14, 1929 and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Appendicial Abscess

Chronic Myocarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Fecal Abscess

Acute Cardiac & Pratter-Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 4/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) S. H. Barnes, M. D.

19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/17 1929
20 UNDERTAKER	ADDRESS
Chas O. Ward & Son	851 N. Mt Royal

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

E 50097

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50097

CERTIFICATE OF DEATH

126

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 16-38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adolph Urban

(a) RESIDENCE NO. 62nd + Clairmont Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Urban

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joe Urban

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Hospital Record

(Address)

15 FILED 1 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/29

17 I HEREBY CERTIFY, That I attended deceased from 9/30, 1929, to 10/14, 1929, that I last saw him alive on 10/14, 1929 and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Extra peritoneal pelvic abscess unknown origin.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 10/10/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical -

(Signed) L. H. Hampson, M. D.

10, 15, 1929 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 17 1929
20 UNDERTAKER	ADDRESS
August Pasch	2706 Ashland Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50098

CERTIFICATE OF DEATH

49 E 50098

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 7[illegible] WARD 63)

2—FULL NAME Agnes Hall

(a) RESIDENCE NO. Mt Hope Retreat ST., 2 8th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — da. How long in U. S., if foreign birth? — yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	if LESS than 1 day, ...hrs. or ....min.
	57	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Unknown
(State or country) Unknown.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mt Hope Retreat
(Address) Mt Hope Retreat

15 Filed [illegible] 5 1929 C. HAMPSON JONES, M. D. Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 15, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 1897 19 . to Dec 15 . 1929, that I last saw h[illegible] alive on Dec 15, . 1929 and that death occurred, on the date stated above, at 9.20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas
Unknown — for years
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chr. Manic Depr. Psychosis
(duration) 32 yrs. 0 mos. 0 da.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Dec 16 29
20 UNDERTAKER	ADDRESS
Stewart & Co	Pueblo.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50099

7A-001 E 50099

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 S Carlton St. 16-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mackie Burton

(a) RESIDENCE NO. 12 S Carlton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Wht	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or ... min..
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Jno. Abell

11 BIRTHPLACE OF FATHER (City or town) Berlin

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Lutz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary E Pratt

(Address) 12 S Carlton

15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1929

6.45 P.M.

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 16, 1929,

that I last saw h... alive on Oct 16, 1929,

and that death occurred, on the date stated above, at 6.45 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Paralysis (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Woodward M. D.

Oct 17, 1929 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

Date of Burial Oct 16th 1929

20 UNDERTAKER C. Jones

ADDRESS 11 S Gilmor

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50100

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 50100

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2707 Vincent ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Ida Eliz Anderson

(a) RESIDENCE NO. 2707 Vincent ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

.a If married, widowed, or divorced, HUSBAND of (or) WIFE of Robt Daniel Anderson

6 DATE OF BIRTH (month, day, and year) May 1879

7 AGE: Years 50 | Months 5 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER Walker Overley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs. Robt. D. Anderson

(Address) 2707 Vincent St.

15 Filed OCT 15 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 13th, 1929, to Oct 13th, 1929, that I last saw her alive on Oct 13th, 1929, and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Conditions

(Signed) A. E. Bell, M. D.

19 (Address) 713 N. Dukeman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 16th 1929

20 UNDERTAKER: A. Jones — ADDRESS: 11 S Eden

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

(Pindell)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50101

CERTIFICATE OF DEATH

E 50101

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Pondent Hosp. ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella L. Pindell

(a) RESIDENCE NO. Waltony Md ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Pindell

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant James Jones

(Address) Waltony Md

15 Filed OCT 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/29

17 I HEREBY CERTIFY, That I attended deceased from 10-8, 19 29, to 10-14, 19 29, that I last saw h alive on 10-14, 19 29, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Uremia Abscess

14

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Acute Lymphadenitis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 10-14

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) B Hanes M. D.

10/15, 19 29 (Address) Pondent Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waltony Md	Oct 17 1929
UNDERTAKER	ADDRESS
R. T. Weldin & Son	Waltony Md

important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 50102

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50102

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 N. Patterson Pk Ave St. Ward) 129 Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Filliaut

(a) Residence No. 1113 N. Patterson Pk. Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Harry Filliaut

6-DATE OF BIRTH (month, day and year) 2. 4. 1862.

7-AGE 67 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Mathias Bauer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Frederika Lemaling

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) Mrs. Minnie Tucker

(Address) 1113 N. Patterson Pk. Ave.

15-

Filed 10 Registrar.

1 5 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct. 13. 29.

17- I HEREBY CERTIFY, That I attended deceased from March 1st 29 to October 13th 29

that I last saw h.. alive on October 12th 29

and that death occurred, on the date stated above, at 4-30 A m.

The CAUSE OF DEATH* was as follows: Chronic Art. Nephritis

Chronic Valv. Heart disease (Duration) 2 yrs. 7 mos. 13 ds.

CONTRIBUTORY (Secondary) (Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What tests were made? Clinical

(Signed) Thos. R. A. Mey er M. D.

Oct. 14. 1929 Address 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto. Cem. DATE OF BURIAL. Oct. 16 1929

20-UNDERTAKER. Philip Herwig ADDRESS 2016 Orleans st

instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50103

14-001

E 50103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1715 S. Charles St. St. 23-34 Ward)

2-FULL NAME Conrad Nicklas.

(a) RESIDENCE NO. 1715 S. Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Annie Nicklas.

6 DATE OF BIRTH (month, day, and year) July 14, 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69	3	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grinder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Casper Nicklas.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Vernon Nicklas. (son)
(Address) 1715 S. Charles St.

15 Filed ....., 19.. C. HAMPSON JONES, M. D.
Registrar

OCT 15 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Heinrandt M. D.

10/15 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baden Hill Cem	Oct 17 1929
20 UNDERTAKER	ADDRESS
A. Leland Evans	38 E. Fort Ave

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50104 | CERTIFICATE OF DEATH | 129 E 50104

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1531 W. Fayette ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A. Walker

(a) RESIDENCE NO. 1531 W. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Rita Walker

6 DATE OF BIRTH (month, day, and year) September 21, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	-	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Blumenthal-Kahn Co.

9 BIRTHPLACE (city or town) (State or country) Spencer County, Ky.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Rita Walker

(Address) 1531 W. Fayette St.

15 Filed OCT 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to Oct 13, 1929, that I last saw h im alive on Oct 13, 1929 and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colon Neoplasm

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur C. Manning M. D.

10-15, 1929 (Address) 800 E. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Oct. 16 1929
20 UNDERTAKER Lord & Cook	ADDRESS 1003 W. Baltimore St

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50105 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 97-002 E 50105

CERTIFICATE OF DEATH

1—PLACE OF DEATH 2439 N Charles St REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. Wm L Ingram

(a) RESIDENCE NO. 2439 N Charles ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 24 1869

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Henderson Kentucky

PARENTS

10 NAME OF FATHER Myrte H Ingram

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.

12 MAIDEN NAME OF MOTHER Cath. Milton

13 BIRTHPLACE OF MOTHER (city or town) Lexington (State or country) Ky.

14 Informant Dr. M L. Ingram

(Address) 2439 N Charles St

15 Filed ... HAMPSON JONES M. D. Registrar

OCT 15 1929

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14/29

17 I HEREBY CERTIFY, That I attended deceased from 10/13/29, 19..., to 10/14, 1929, that I last saw him alive on 10/14, 19 29, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Rt. Frontal Sinus Infection

(duration) ... yrs. 9 mos. ... ds.

CONTRIBUTORY (Secondary) Infection of Brain

(duration) ... yrs. 7 mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown. Frontal Sinus Op.

Did an operation precede death? ... Date of ...

Was there an autopsy? No Come to hospital

What test confirmed diagnosis? Symptoms & Treatment

(Signed) ... M. D.

. 19 (Address) Patterson Pk.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Oct 16 1929
20 UNDERTAKER	ADDRESS
Williams Cook	1217 St Paul St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50106

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 50106

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Eyring

(a) RESIDENCE NO. 2420 Fait ave. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank C. Eyring

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. T. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 15 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1928, to Oct. 15, 1929, that I last saw her alive on Oct. 15, 1929 and that death occurred, on the date stated above, at 9.05 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Edmunds M. D.

10-15 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL 10/18 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50107

HEALTH DEPARTMENT—CITY OF BALTIMORE

48 E 50107

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 12-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Myers

(a) RESIDENCE NO. 2201 Oak St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): York, Penna.

12 MAIDEN NAME OF MOTHER: Margaret Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York, Pa.

14 Informant: Records of

(Address): Balto. City Hospitals

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

1 5 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 19 29, to Oct. 14, 19 29, that I last saw him alive on Oct. 14, 1929 and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Diffuse

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (over)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) K. A. Lumpkin, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Oct. 16 1929
20 UNDERTAKER: Wm Cook	ADDRESS 1217 St Paul St

Important: See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50108

CERTIFICATE OF DEATH

90 E 50108

1—PLACE OF DEATH

REGISTERED NO. 9-47

CITY OF BALTIMORE: (No. 3316 Elleralie Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Henrietta Wagner

(a) RESIDENCE NO. 3316 Elleralie Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

6a If married, widowed, or ~~divorced~~
(or) WIFE of Conrad Wagner

6 DATE OF BIRTH (month, day, and year) Jan 29.1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Stutt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs William A. Smith

(Address) St Paul & Chase Sts

15 Filed 1 5 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October.13.1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to October 13, 1929, that I last saw h alive on October 13, 1929 and that death occurred, on the date stated above, at 1;10 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duratinn) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Stull M. D.

. 19 (Address) Wyliesville Rinkedownville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 16/29
20 UNDERTAKER	ADDRESS
Hughes & Sons Co	424 N. Broadway

E. HAMPSON JONES, M.D.
Registrar

Important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

E 50109

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50109

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 13-39 25-00K

CITY OF BALTIMORE: (No. 2857 Woodbrook Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Catherine Erdmann

(a) RESIDENCE NO. 2857 Woodbrook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Charles C. Erdmann

6 DATE OF BIRTH (month, day, and year) June 16, 1859.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry J. Schaub

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Schuler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Elsie Smith

(Address) 2857 Woodbrook Ave

15 Filed OCT 18 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14-29

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1928, to Oct 14, 1929

that I last saw her alive on Oct 13, 1929

and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/15/29 (Address) 1707 W. Monta ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Oct. 16, 29

20 UNDERTAKER Harry N. Witzke ADDRESS 1531 W. Lombard

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Mary Parker

E 50110 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50110

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 835 Clancy ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Parker

(a) RESIDENCE NO. 835 Clancy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Parker

6 DATE OF BIRTH (month, day, and year) Dec 22-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Selena Cuningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Julia Miller

(Address) 1518 Hinsdale Ave.

15 Filed OCT 16 1929 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-12-29

17 I HEREBY CERTIFY, That I attended deceased (from Oct 12, 1929, to Oct 12, 1929, that I last saw h[illegible] alive on Oct 11, 1929, and that death occurred, on the date stated above, at 5.55 9 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Oct. 16 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 3712 N. Schroeder St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50111 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50111

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1112 W. Hamburg S ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H. Frank

(a) RESIDENCE NO. 1112 W. Hamburg ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Frank

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

(c) Name of employer Public Schools

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Frank

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Gehring

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Johanna Frank
(Address) 1112 W. Hamburg St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1929.

17 I HEREBY CERTIFY, That I attended deceased from 9-20-29, 19..., to 10-13-29, 19..., that I last saw him alive on 10-13-29, and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) J. Ferd Waesche, M. D.

10/13 1929 (Address) 1126 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Oct 17 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

IMPORTANT.—See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50112

E 50112

CERTIFICATE OF DEATH.

119

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ST. 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ida Berman

(a) RESIDENCE No. 1113 E. Lombard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Milton Berman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ella —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mary Gottlieb

(Address) 1718 E Balt St

15 Filed 10 6 1929 C. HAMPSON JONES, Registrar By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 15, 1929, that I last saw h ev alive on Oct 15, 1929, and that death occurred, on the date stated above, at 4:25 p. m.

The CAUSE OF DEATH* was as follows:

Fecal fistula

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Peritonitis & acute myocardial failure (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 3 '29

Was there an autopsy? No.

What test confirmed diagnosis? History, Physical operation

(Signed) C. Hyman M. D.

10/15 1929 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 10/16 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1429 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 50113

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50113

188-103

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Joseph's Hosp. St., 8-13 Ward)

2-FULL NAME Hatty Hopkins

(a) RESIDENCE NO. 1616 E. Chase St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Hopkins

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE: Years 72 | Months — | Days — | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town)
(State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph Hopkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Russia

14 Informant: Jack Lewis
(Address): 1439 E Baltimore St

15 Filed OCT 16 1929 19... C. HUNSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion Chest — Hemorrhage caught between in plat form and backing auto + his chest was crushed (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Traumatic shock (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Bay + Chase Sts

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Frame, M. D.

10/16 19 9 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hebrew Rest

DATE OF BURIAL: 10/16 19 29

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-2[illegible] A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50114

CERTIFICATE OF DEATH

179 E 50114

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 10-64 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Edward Nuff

(a) RESIDENCE NO. 2680 Wilkins Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Colur or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 60
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Nuff

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Shokrs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant
(Address) 2680 Wilkins Ave

15 Filed....., 19..... Registrar

OCT 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 19

17 I HEREBY CERTIFY, That I took charge of remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
First & second degree burns of body & legs - caused by ammonium hydroxide
Accidental Death (duration) mos.
CONTRIBUTORY (Secondary) Oedema of lungs.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? 2680 Wilkins Ave
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene Gallet M. D.
10/15. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Oct 17

20 UNDERTAKER Arthur Fields 1100 W Lanvale

ADDR

E 50115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-00

E 50115

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sheron Booker

(a) RESIDENCE NO. 2115 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Booker

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Solomon Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm Booker

(Address) 2115 Division St

15 Filed ....., 19.. C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14-24

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 19 24, to Oct 14, 19 24

that I last saw her alive on Oct 14, 19 24

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 11, 24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) B H Jones M. D.

10/14, 19 24 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem Co DATE OF BURIAL 10/17/24

20 UNDERTAKER Samuel Wensley ADDRESS 1518 Bridge

important. See instruction

Spec.—1-12-23—M&T—500 Blks.

DAVIS

E 50116 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 50116

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Davis

(a) RESIDENCE NO. 1528 N. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 17 1887

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
41	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Cottley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Clarence E. Davis 1528 N. Carey St

15 Filed 10 6 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 14 1929.

that I last saw h alive on Oct 14, 1929

and that death occurred, on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulo Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory

(Signed) J. T. Scarpa, M. D.

, 19 (Address) Mt. Wolfe Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Thomas Cem. DATE OF BURIAL Oct 16 19 29

20 UNDERTAKER Samuel J. Hensley ADDRESS 1128 N. Bradford

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 50117

1—PLACE OF DEATH

REGISTERED NO. 17-26

CITY OF BALTIMORE: (No. 608 Brune ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David E Christy

(a) RESIDENCE NO. 608 Brune ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Beatrice Christy

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jas. Christy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Bagwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Bruce Christy (Address) 608 Brune St

15 Filed OCT 16 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13/29

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to Oct 13, 1929

that I last saw him alive on Oct. 13, 1929

and that death occurred, on the date stated above, at 10.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) Dank E. Wagner M. D.

10/14, 1929 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Oct 16 29

20 UNDERTAKER Samuel Kennedy

ADDRESS W Biddle

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50118 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 50118

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Jackson ST. 24-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer Barnes

(a) RESIDENCE NO. 1802 Jackson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 25-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elmer Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bessie Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Addie Neal

(Address) 1802 Jackson St

15 Filed 10 16 1929 C. HARPER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 14, 1929.

that I last saw him alive on Oct 14, 1929

and that death occurred, on the date stated above, at 8-35 P. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Michelle M. D.

10/15 1929 (Address) 1279 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem — DATE OF BURIAL 10/17 1929

20 UNDERTAKER L. F. McCully — ADDRESS 130 E Fay

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50119 ✓ 74-08 E 50119

CERTIFICATE OF DEATH

E 50119

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 782 Bradley ST., 17-26 WARD)

2—FULL NAME Henry Hoketon Williams

(a) RESIDENCE NO. 782 Bradley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17-1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Hthelton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. Handy

(Address) 1511 Fairmount Ave

FEB 16 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 12. 1929 to Oct 14. 1929

that I last saw him alive on Oct 14. 1929

and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Coakley, M. D.

, 19 (Address) 729 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	10-17-29

20 UNDERTAKER ADDRESS

Geo. Wm. Skinner 1625 E. Madison

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50120

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50120

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 24-001

CITY OF BALTIMORE: (No. 1316 N. Carey ST. 15-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna C Reed

(a) RESIDENCE NO. 1316 N. Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J Reed.

6 DATE OF BIRTH (month, day, and year) May 16-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	68	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Burkard Credit

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary E. Oneill

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mary Genesta Emberg

(Address) 631 Cumberland St

15 Filed OCT 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 13, 1929, that I last saw h.. alive on Oct 11, 1929 and that death occurred, on the date stated above, at 12:20 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Hemiplegia 2nd attack
First Oct 1926 (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cystitis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm H Wright, M. D.

Oct 13, 1929 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	Oct 16 1929
20 UNDERTAKER Mrs R. G. Elliott	ADDRESS 172 Cathedral

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Mks.

PEALES

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 50121

E 50121

3 √

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 775 N Schroeder 18-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Peales

(a) RESIDENCE NO. 775 N Schroeder ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 15-1899

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) at large

(c) Name of employer Out of employment.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Peales

11 BIRTHPLACE OF FATHER (city or town) Howard Co

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Agnes Dockery

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mary Agnes Peales

(Address) 775 N Schroeder St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929, to Oct 14, 1929, that I last saw h— alive on Oct 13, 1929, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

accessory to Malnutrition

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

10/14, 1929 (Signed) J. Chesney S. Faust, M. D.

(Address) 17 of Commissioner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL Oct 17, 1929

20 UNDERTAKER Mrs. Nate R. Williams

ADDRESS 327 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 16 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 50122

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50122

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3401 Mondawmin St. 45-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Trusheim

(a) RESIDENCE NO. 3401 Mondawmin St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

(a) If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna M. Trusheim

6 DATE OF BIRTH (month, day, and year) Nov 10 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper & Cost

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Trusheim Elec Co

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER Jacob Trusheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Lester Trusheim

(Address) 3401 Mondawmin St

Filed OCT 16 1929 C. HAMPSON JONES, M.D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14-1929

17 I HEREBY CERTIFY, That I attended deceased from 6-21-29, 19..., to 10-14-29, 19..., that I last saw him alive on 10-14-29, 19... and that death occurred, on the date stated above, at 10-59 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Right Kidney

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examinatio

(Signed) Dr J Thrasher M. D.

19 (Address) 3400 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 17 1929
20 UNDERTAKER Dr J Tuckner & Sons	ADDRESS Mt Pa Ave

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 50123 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO. .....

CITY OF BALTIMORE: (No. Howards Mad ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Griffith

(a) RESIDENCE NO. Harrison, md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Aug 8 - 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ud

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Herbert Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel Hardesty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Richard.

15 Filed OCT 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1929 to Oct 16, 1929.

that I last saw him alive on Oct 16, 1929,

and that death occurred, on the date stated above, at 10.28 a.m.

The CAUSE OF DEATH* was as follows:

Appendicial abscess.

(duration) ..... yrs. ..... mos 21 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Oct 7, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation & Clinical

(Signed) H. L. Kretschmer M. D.

Oct 16 1929 (Address) Md Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Hill Cemetery	Oct 18 1929

20 UNDERTAKER	ADDRESS
Bate Co	Md
A. F. Edna Rutledge	Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50124 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 S. 6th " ST., Brooklyn WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella W. Heems

(a) RESIDENCE NO. 815 S. 6th St. ST., Brooklyn WARD Balto

(Usual place of abode)

Length of residence in city or town where death occurred Life — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: Frederick L. Heems

6 DATE OF BIRTH (month, day, and year): August 9th 1887

7 AGE — Years: 42 — Months: 2 — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brooklyn Balto Md.

PARENTS

10 NAME OF FATHER: George Potee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Hortman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Frederick L. Heems

(Address) 815-S 6th St Brooklyn Balto.

15 Filed OCT 16 1929, 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 14th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 10th, 1929, to Oct 14th, 1929, that I last saw her alive on Oct 13th, 1929, and that death occurred, on the date stated above, at 9:53 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of uterus

(duration) yrs. 5 mos 4 ds.

CONTRIBUTORY (Secondary): Cachexia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted, if not at place of death? At place of death

Did an operation precede death? Yes Date of May 15th 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Tony Heibel, M. D.

(Address) 1214-12 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. — DATE OF BURIAL: Oct 16th 1929

20 UNDERTAKER: Leo G. Cook — ADDRESS: 1423 Pat. Pk Ave

TION is very important. See instructions on back of certificates.

E 50125

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50125

CERTIFICATE OF DEATH

REGISTERED No. C 57

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 700 E Bond St. 3-H WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bella Lewitz

(Residence in Baltimore: No. 700 E Bond St. 2 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (If write the word): Widow

6 DATE OF BIRTH: ——— (Month) , 1 (Day) (Year)

7-AGE: 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Lewis

(Address) 1439 E Balto St

15. Filed OCT 16 1929 C. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 10 (Month) 16 (Day) , 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929 to Oct 15 1929

that I saw h— alive on Oct 15, 1929

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Arteriosclerosis

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Hyman Berry M. D.

10/16, 1929 (Address) 2100 E Fairmount Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: New Mt. Carmel — DATE OF BURIAL: 10-16-1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

T 16 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50126

CERTIFICATE OF DEATH

1 98 E 50126

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 17-25 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Cooper.

(a) RESIDENCE NO. 637 Pierce. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O&D
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant P. W. Police Board
(Address)

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

OCT 16 1929 BY .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (due to loss of Blood) (duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Gun shot wound of Buttock (duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted If not at place of death? 605 Block Pierce St

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Regular Autopsy

(Signed) ..... M. D.

Oct 17, 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

Commissioner Health.

OCT 16 19

FOR CITY REGISTRAR

IMPORTANT. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50127

66 E 50127

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 405 Lewis St., 5-8 Ward)

2-FULL NAME Sarah Tillman

(a) RESIDENCE NO. 405 Lewis St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
about 42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) "

14 Informant Police
(Address)

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

OCT 6 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 25/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia

..... (duration) about 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism & Exposure

..... (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. E. Jones, M. D.

10/3/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER
Commissioner Health

ADDRESS OCT 16 192

FILED FOR RECORD

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 50128

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50128

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 Harlem Ave ST.) 16-69 (WARD)

2-FULL NAME Henrietta Schneider

(a) RESIDENCE NO. 2321 Harlem Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Frank Schneider

6 DATE OF BIRTH (month, day and year): Sept. 22, 1860

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Conrad Weidhardt.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rosa Lehr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Louisa C. Schaugs

(Address) 2321 Harlem Ave.

15 6 1929 . 19 . E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct. 14 1929

17

I HEREBY CERTIFY, That I attended deceased from August 15. 1929. to October 14. 1929.

that I last saw her alive on October 13. 1929.

and that death occurred, on the date stated above, at 6,30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arterio Sclerosis

(duration) 3. yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac decompensation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Chas. Wilbur Stewart M. D.

10/14 1929 (Address) 1738 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL: Loudon Park.

DATE OF BURIAL: Oct. 17 1929

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50129

CERTIFICATE OF DEATH.

185 E 50129

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Memorial Hospital St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest C Board

(a) RESIDENCE NO. 2307 Dupont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ada Board

6 DATE OF BIRTH (month, day, and year) 12-14-82

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Salt Ind

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) ?

14 Informant Ada Board
(Address) 2307 Dupont St

15 Filed ....., 19..

T 16 1929

C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

CAUSE OF DEATH* was as follows: Fractured skull Intense Injuries - Fell from Horse - accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. J. Mossman M. D.
(Coroner)

10/15 1929 (Address) 3672 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — Date of Burial: Oct. 17 1929

20 UNDERTAKER: Wm. L. Miller Sons — ADDRESS: 2334 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50130

CERTIFICATE OF DEATH

90 E 50130

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 626 St Annes Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Mc" Grath

(a) RESIDENCE NO. 626 St Annes Ave WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Agnes Burden

6 DATE OF BIRTH (month, day, and year) 3/16/1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Mc" Groth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER J. Mc" Culliff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Thomas Monahan

(Address) 626 St Annes Ave

15 Filed OCT 16 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 / 14 / 29

17 I HEREBY CERTIFY, That I attended deceased from 9 / 1 / 29, to 10 / 14 / 29,

that I last saw h— alive on 10 / 14 / 29,

and that death occurred, on the date stated above, at 11-a m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis
Acute Dilatation

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertension, Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas F Kelly, M. D.

, 19 (Address) 532 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct 17 1929

20 UNDERTAKER Mary M Medefield ADDRESS 501 E 22nd St

Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50131

CERTIFICATE OF DEATH.

129 E 50131

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1921 Frederick Ave. 20-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Armanda B. Hughes

(a) RESIDENCE NO. 1921 Frederick Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Richard A. Hughes

6 DATE OF BIRTH (month, day, and year): Sept. 24/1868

7 AGE: Years 61 | Months — | Days 20 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Indnsiry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.,

(State or country): Ind.

PARENTS

10 NAME OF FATHER: William Boswell

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ind.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto. Ind.

14 Informant: Richard A. Hughes

(Address) 1921 Frederick Ave.

15 Filed: T 16 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1 1929 to Oct 13 1929, that I last saw h[illegible] alive on Oct 13 1929, and that death occurred, on the date stated above, at 1150 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Obstruction

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Surgery

(Signed) [illegible], M. D.

, 19 (Address) 543 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery Date of Burial: Oct. 17 1929

20 UNDERTAKER: George L. Schwab ADDRESS 2101 Frdk. Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 50132 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. E 50132

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 16-32 WARD)

2-FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 1215 Winchester ST., WARD Odenton - Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? - 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Brother-in-law (Address) 1015 Hanover St.

16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-15-29

17 I HEREBY CERTIFY, That I attended deceased from 10-4-29, 19..., to 10-15-29, 19..., that I last saw h.r alive on 10-15-29, 19..., and that death occurred, on the date stated above, at 5-00 A.m.

The CAUSE OF DEATH* was as follows:

Nephritis Uremia

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) C. L. Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Odenton Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Widal

(Signed) Geo. McDonald, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Tabor, Md.	10/18/29
UNDERTAKER Mrs. Lee. H. Holland	ADDRESS 1681 Druid Hill

CAUSE OF DEATH must be stated plainly. Consult your family physician if you are in doubt. Do not use abbreviations or initials. Do not state the mode of dying, as shock, exhaustion, etc., but the disease or injury which caused it. Additional information may be given on back of certificates.

IMPORTANT. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 50133

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50133

CERTIFICATE OF DEATH.

100-801

1-PLACE OF DEATH

City of BALTIMORE: (No. 1529 McCulloh St. H-20 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Berard L. Allen

(a) Residence No. 1529 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 19-1929

7-AGE, yrs. 6 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9-BIRTHPLACE (city or town) Md (State or Country),

PARENTS.

10-NAME OF FATHER, B. E. V. Allen

11-BIRTHPLACE OF FATHER (city or town) Va. (State or Country),

12-MAIDEN NAME OF MOTHER, Julia Blacken

13-BIRTHPLACE OF MOTHER (city or town) Va. (State or Country),

11- (Informant) Mrs. E. V. Allen

(Address) 1529 McCulloh St.

15- Filed C. HAMPSON JONES, M. D. Registrar.

15 1929 By ORH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 16 1929

17- I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Oct 16, 1929, that I last saw him alive on Oct 16, 1929, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Warren Williams M. D.

10-16, 1929 (Address) 1530 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL, 10/17/ 19 29

20-UNDERTAKER Mrs Lea H. Holland — ADDRESS 1631 Druid Hill

instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50134

CERTIFICATE OF DEATH

16-002

E 50134

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 E. Baylis ST. 7-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah J. Schneider

(a) RESIDENCE NO. 1005 E. Baylis ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Schneider

6 DATE OF BIRTH (month, day, and year): Jan 22 1855

7 AGE: Years 74 | Months 8 | Days 22 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 31

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles Francis

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: John F. Schneider

(Address): 1005 E. Baylis St

15 Filed 6 1929, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 29th, 1929, to Oct. 14th, 1929, that I last saw her alive on October 13th, 1929 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Enteroc Colitis

(duration) yrs. mos. 2 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) David W. Jones, M. D.

10/15, 1929 (Address) 1011 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: Oct 17 1929

20 UNDERTAKER: H. Sander Sons Inc — ADDRESS: 1710 Pratt

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

E 50135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 50135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3720 Eastern Ave. 26-37 Ward)

2-FULL NAME John V. Meisenhalder

(a) RESIDENCE NO. 3720 Eastern Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Meisenhalder

6 DATE OF BIRTH (month, day, and year): June 5 - 1876

7 AGE — Years: 53 — Months: 4 — Days: 10 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Harness-makr

(b) General nature of industry, business, or establishment in which employed (or employer): Self 388

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Joseph Meisenhalder

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Henritta Schroeder

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Amelia Meisenhalder

(Address) 3720 Eastern Ave

15 10 16 1929 C. HAMPSON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Gustave Fiedler M. D.

(Coroner)

10/16, 1929. (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial: Oct. 18, 1929

20 UNDERTAKER: Henry Sander & Sons. Inc. — ADDRESS: Baltimore St. & Broadway

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50136

E 50136

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4323 Belvieu Avenue St. 28-63 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles K. Clifford

(a) RESIDENCE NO. 4323 Belvieu Avenue St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Clifford

6 DATE OF BIRTH (month, day, and year) September 19, 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76	-	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Clifford

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda M. Clifford

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Miss Ruth M. Clifford

(Address) 4323 Belvieu Avenue

15 Filed ..... 19.. ..... M. D.

Registrar

T 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) F. C. Kuck, M. D. (Coroner)

10/15 1929 (Address) North Ave. and Division Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery Date of Burial Oct. 17 1929

20 UNDERTAKER Joseph Cook ADDRESS 1003 West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50137

CERTIFICATE OF DEATH

91-002 E 50137

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2503 W. Baltimore ST. 21-L WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Thomas Sipes

(a) RESIDENCE NO. 2503 W. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma S. Sipes

6 DATE OF BIRTH (month, day, and year) June 10,1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Trainman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. &O.R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Maryland.

PARENTS

10 NAME OF FATHER Ephrain Sipes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co., Md.

12 MAIDEN NAME OF MOTHER Elizabeth Fryfogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Emma S. Sipes

(Address) 2503 W. Baltimore St. M D

15 Filed 10 6 1929, 19 C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14,1929

17 I HEREBY CERTIFY, That I attended deceased from October 12, 1929 to October 15, 1929

that I last saw h alive on October 15, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Elder Mansfield M. D.

10/16, 1929 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct.17 1929

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 W. Baltimore St.

IMPORTANT.—SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Bks.

E 50138 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50138

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 808 W Lombard ST., 18-29 WARD) REGISTERED NO. 90

2-FULL NAME Harry E Houck

(a) RESIDENCE NO. 808 W Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Aug 11, 1891

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
38	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Frederick Co Md

PARENTS

10 NAME OF FATHER: Eugene E Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co Md

12 MAIDEN NAME OF MOTHER: Lillie D. Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co Md

14 Informant: Mrs. L. D. Houck

(Address) 808 W Lombard St

Filed 10/16 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Oct 15, 1929, that I last saw him alive on Oct 15, 1929, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'Neill M. D.

10/16 1929 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem Frederick Md Oct 18" 1929

20 UNDERTAKER: Joseph L Cook

ADDRESS: 1003 W Lexington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50139

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3320 Elleslie ave ST. 9-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Kluter

(a) RESIDENCE NO. 3320 Elleslie ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Kluter

6 DATE OF BIRTH (month, day, and year) Jan. 9. 1877

7 AGE Years 52 | Months 9 | Days 10 | If LESS than 1 day, hrs. or min. 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lemonades

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Chas. Kluter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Mary H. Brill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna E. Kluter
(Address) 3320 Elleslie ave

15 Filed OCT 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 22, 19 29, to Oct 14, 19 29, that I last saw h[e] alive on Oct 14, 19 29 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, & St Nephritis,
Ch. Myocarditis

(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. W. Bishop, M. D.

(Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. | DATE OF BURIAL Oct. 17 19 29

20 UNDERTAKER J. J. Moran | ADDRESS 300 E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 50140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001

E 50140

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice L. Huntsberger

(a) RESIDENCE NO. 1421 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? 78 yrs. 5 mos. 14 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Calvin Huntsberger

6 DATE OF BIRTH (month, day, and year) May 2-1851

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Hoffelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Mary Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Daniel G. Huntsberger

(Address) 1421 W. Lexington St.

15 OCT 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1929. to Oct. 16, 1929. that I last saw h.. alive on Oct. 16, 1929 and that death occurred, on the date stated above, at 1/2 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory

(Signed) Arthur Patterson M. D.

10/16 1929 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chambersburg Pa.	Oct. 17 1929

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 W Balto

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

James E Scrivener

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50141

CERTIFICATE OF DEATH

× 58-001

E 50141

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST., 4-30 WARD)

2—FULL NAME James E. Scrivener

(a) RESIDENCE NO. Fairhaven, Md., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland,

PARENTS

10 NAME OF FATHER James E. Scrivener.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Kate Garner

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant James E. Scrivener.
(Address)

15 Filed OCT 17 1929 19 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1929,

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1929, to Oct. 16, 1929, that I last saw h[illegible] alive on Oct 16, 1929, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia
Chronic Enterocolitis Gastritis

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia,

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no,

What test confirmed diagnosis? Physical Signs,

(Signed) E. T. Siebach, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St James. Chapel. A.A.Co	10/18 1929
UNDERTAKER Henry W. Adkins Inc Co	ADDRESS Edward Inc Eutaw

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50142

1—PLACE OF DEATH

REGISTERED NO. 11-25-90

CITY OF BALTIMORE: (No. 616 Park Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nora Brosnan

(a) RESIDENCE NO. 616 Park Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Not obtainable

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About 71		?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Brosnan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER -----Broderick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

11 Informant Mrs. Mary Gloster

(Address) 2694 Wilkens Ave.

15 Filed 1 7 1929, 19 CLAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 8th, 19 29, to Oct 16, 19 29 that I last saw h. alive on Oct 16, 19 29 and that death ocrurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Stomach Auto Intoxication

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Typical Signs & Symptoms

(Signed) Thomas J. Ruhr, M. D.

, 19 (Address) 532 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct. 18, 1929
20 UNDERTAKER H. W. Means & Son	ADDRESS 745 N. Calvert St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50143

CERTIFICATE OF DEATH

31 ✓ E 50143

REGISTERED NO.

1-PLACE OF DEATH Enroute

City of Baltimore: (No. Hopkins Hospital St., 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milford Wilson

(a) RESIDENCE NO. 1213 N. Eden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	black	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Wilson

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Autotruck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) 023
(c) Name of employer Geo. W. Cooper

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Wilhelmina Lee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mother
(Address) 1213 N. Eden St

15 Filed ....., 19.... C. H[illegible] JONES, Registrar

OCT 17 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from mouth-
Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

10-16-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-17 1929
20 UNDERTAKER	ADDRESS
Byron Wright	218 McCulloh St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-281 E 50144

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 N. Fayette ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Lupton

(a) RESIDENCE NO. 2112 N. Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Lupton

6 DATE OF BIRTH (month, day, and year) Oct 14-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	0 7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Hiram Lupton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Haigrove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary E Lupton

(Address) 2112 N. Fayette St

15 Filed ..., 19 C. HARRISON JONES, M. Registrar Per

OCT 17 1929

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14-1929.

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to Oct 14-, 1929 that I last saw h wife alive on Oct 14-, 1929 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) 6 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis & Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure & Hemiplegia

(Signed) Chas A Carter, M. D.

1929 (Address) 2107 N Bells 4

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Oct 17 1929

20 UNDERTAKER John Merrick — ADDRESS 2008 Adams

Spec.—8-16-29—L. F. S.—100 Bks.

E 50145

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50145

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

REGISTERED NO. 13-59

CITY OF BALTIMORE: (No. 2118 Callow ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Greenberg

(a) RESIDENCE NO. 2118 Callow ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth 21 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Greenberg

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Sarah

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pinkus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Greenberg Bros

(Address) 2118 Callow ave

15 Filed OCT 17 1929 19 G. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16/29

17

I HEREBY CERTIFY, That I attended deceased from 10/30, 1928, to 10/16, 1929, that I last saw her alive on 10/16, 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Kidney

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Specimen

(Signed) David Bramden, M. D.

10/16, 1929 (Address) 122 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern ave

DATE OF BURIAL 10/17 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1409-6 Balto st

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 50146

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 3-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Andrzjewski

(a) RESIDENCE NO. 1614 Gough St., Ward

(Usual place of abode) Tile

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1921

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	8	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wladyslaw Andrzejewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Kalinowski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Father
(Address) 1614 Gough St

15 Filed 19 C. HUNTER JONES
Registrar

OCT 17 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-Accidental Burns over lower half of body. Clothes caught fire while at play. (Sep 9/29)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 200 block S Broadway

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. H. Owens, M. D.

10/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Oct 18 1929
20 UNDERTAKER	ADDRESS
F. W. Ozazewski	1930 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks.

E 50147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50147

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3120 O.Donnell St. ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Skozilas

(a) RESIDENCE NO. 3120 O.Donell St. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Skozilas

6 DATE OF BIRTH (month, day, and year) Unk.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocerman

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Bert Skozilas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Labunska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant J. Skozilas

(Address) 3120 O Donell St

15 OCT 17 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15. 29

17 I HEREBY CERTIFY, That I attended deceased from June 19 1929 to Oct 15 1929

that I last saw him alive on Oct 15 1929

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) asthma (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy

(Signed) Wm Lebutter, M. D.

10/17. 1929 (Address) 1219 Leighton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Oct 18, 9

20 UNDERTAKER F. W. Ozazewski 193 Eastern Ave

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50148

CERTIFICATE OF DEATH

112 ✓ E 50148

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 5-8 Ward)

2-FULL NAME Hattie Hilson

(a) RESIDENCE NO. 222 Colvin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Sept 25, 1889

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
40	0	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

041

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Annie Brooks
(Address) 222 Colvin St

15 Filed ....., 19.... C. HAMPSON JONES, M.D. Registrar

OCT 17 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereof and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Cerebral Hemorrhage

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (a) Carcinoma Breast 1 yr

(duration) yrs. mos. 1 ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What (if confirmed) diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Oct	18 1929

20 UNDERTAKER ADDRESS

Joseph A Swirsky 401 N Mount St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50149

CERTIFICATE OF DEATH

33 ✓ E 50149

E 50149

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 Myrtle St. ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Brooks

(a) RESIDENCE NO. 1129 Myrtle Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: R. Brooks

6 DATE OF BIRTH (month, day, and year): Dec 13, 1905

7 AGE: 22 Years 10 Months 2 Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domes

(b) General nature of industry, business, or establishment in which employed (or employer): 057

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Abbe Duff

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Jennie Duff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Jennie Duff

(Address): 1129 Myrtle Ave

15 Filed ..... 19 ..... E. HAMPSON JONES, Registrar

OCT 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 15 '29

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 15, 1929, that I last saw her alive on Oct 12, 1929, and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonal Tuberculosis

(duration) ..... yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Fletcher M. D.

10/16, 1929 (Address) 1125 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: Oct 18 1929

20 UNDERTAKER: Joseph A. Selby — ADDRESS: 4028 Main St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50150

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3011 Belvidere Ave ST., 27-56 WARD)

2—FULL NAME John G. Sapp

(a) RESIDENCE NO. 3011 Belvidere ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Laughlin

6 DATE OF BIRTH (month, day, and year) Sept 21 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Shipwork

(c) Name of employer Terminal Shipping Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Sapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Catherine Sapp

(Address) 3011 Belvidere Ave

15 Filed 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to Oct 16, 1929,

that I last saw h.. alive on Oct 16, 1929

and that death occurred, on the date stated above, at 12:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis 2 wks.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 19 1929
20 UNDERTAKER	**ADDRESS**
Chas L. Stevens	150 E Fort

Cor.—10-10-29—A Co.—100 Bks.

E 50151

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50151

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Madison ave St Mary's ~~Ward~~

2-FULL NAME Clarence Duffkins

(a) RESIDENCE NO. 409 Moore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	36	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Phillip Duffkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hawkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Christina Barnes
(Address) Owens station

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Skull fractured
Run down by auto thereon
contusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic shock

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Madison Ave & St Marys St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H. Brame M. D.

10/16 1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Owens Station Colored	10-17 1929
20 UNDERTAKER Daniel Carlon	ADDRESS 716 Ea ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50152

CERTIFICATE OF DEATH

89 E 50152

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 130 N. Milton ave STREET 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise F. Singley

(a) RESIDENCE NO. 130 N. Milton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65yr mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced (or) WIFE of Henry Singley

6 DATE OF BIRTH (month, day, and year) Dec 9/62

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9 10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo. Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Anna K. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Henry Singley

(Address) 130 N. Milton ave

15 OCT 17 1929 Filed 19 E. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1929, to Oct 14, 1929

that I last saw h alive on 19

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Oct 17 1929
20 UNDERTAKER Philip Herring	ADDRESS 2016 Arlington Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 50153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50153

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1940 N. Gay ST., 8-16 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Rettberg

(a) RESIDENCE NO. 1940 N. Gay ST., [redacted] WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

If married, widowed, or divorced HUSBAND of (or) [redacted] of the late Mary Rettberg

6 DATE OF BIRTH (month, day, and year) Oct 13/54

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): himself 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Christian Rettberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Information: Henry W. Rettberg
(Address) 1940 N. Gay St.

15 OCT 17 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15/29

17 I HEREBY CERTIFY, That I attended deceased from Apr 17, 1929, to Oct 15, 1929, that I last saw h[redacted] alive on [redacted] and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen W. White M. D.

1918, 1929 (Address) 2600 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Balto Cem. DATE OF BURIAL: Oct. 18 1929

20 UNDERTAKER: Philip Herring ADDRESS 2016 Orleans St.

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 E 50154

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 16-bed WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Allen Anderson

(a) RESIDENCE NO. 2711 Winchester ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if foreign birth? 23 yrs. [illegible] mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Anderson

6 DATE OF BIRTH (month, day, and year) [illegible] 17 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stonemason

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER James Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Catherine Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Hospital Records

(Address)

15 Filed OCT 17 1929 C. HERBERT JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to Oct. 14, 1929.

that I last saw him alive on Oct. 14, 1929

and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Jas Hume, Jr. M. D.

10-14 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Oct 17, 1929

20 UNDERTAKER Philip Sterig

ADDRESS 2016 Eutaw St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50155

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 50155

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Schindele

(a) RESIDENCE NO. 640 E. Fort ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Catherine ~~Unknown~~ Schindele

6 DATE OF BIRTH (month, day, and year) Aug 4th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	2	1	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Solderer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Christo Schindele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schindele

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address)

15 Filed OCT 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1929, to Oct. 15, 1929, that I last saw h. alive on Oct. 15, 1929 and that death occurred, on the date stated above, at 10.35 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver (secondary)

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas. D. Arnold, M. D.

10-15 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. P. Carmel DATE OF BURIAL Oct 18 1929

20 UNDERTAKER Philip Stewig ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 38

E 50156

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 834 S. Eutaw ST. 34 WARD)

2—FULL NAME Ida Lester

(a) RESIDENCE NO. 834 S. Eutaw ST., " WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col'd	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Lester

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Fannie T. Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant York Bryan

(Address) 834 S. Eutaw St.

15 Filed ..... 19 .....

OCT 17 1929 C. HARRISON JONES, [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/15/29

17 I HEREBY CERTIFY, That I attended deceased from 10/1/29 to 10/15/29.

that I last saw h alive on 10/14/29.

and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

probably (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

10/16/29 (Address) 708 Shard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Claremont Va	Oct 1 1929
20 UNDERTAKER	ADDRESS
C. A. Brumsted Son	Va. Williamsburg

Spec.—2-29-28—L. F. S.—500 Bks.

E 50157

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50157

129 ✓

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 27-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 217 Gork Road ST. (WARD)

2—FULL NAME George W. Reed

(a) RESIDENCE NO. 217 Gork Road ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie D. Reed

6 DATE OF BIRTH (month, day, and year) March 14 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Fannie D. Reed

(Address) 217 Gork Road

15 Filed OCT 17 1929 HAMPSON JOHNS, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15-29

17 I HEREBY CERTIFY, That I attended deceased from April 2 1929 to Oct 15 1929

that I last saw h[im] alive on Oct 15 1929

and that death occurred, on the date stated above, at 8:50 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis
Arteriosclerosis

(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs mos. 10 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) S. W. Bishop, M. D.

Oct 16, 1929 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 17 1929
20 UNDERTAKER	ADDRESS
Chas. G. Black & W. Southard	

Spec.—7-17-26—A Co.—200 Bks.

E 50158

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50158

CERTIFICATE OF DEATH

161-00

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1222 S. Ellwood ave St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Grabowski

(a) RESIDENCE NO. 1222 S. Ellwood ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or 10 min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Frank Grabowski

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country)

12 MAIDEN NAME OF MOTHER Rose Stankowski

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Rose Grabowski

(Address) 1222 S. Ellwood ave.

Filed OCT 17 1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15 19 29

17 I HEREBY CERTIFY, That I attended deceased from October 15 19 29 to ~~19~~

that I last saw him alive on Stillborn Octo 15 19 29.

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Stillbirth

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) Edward Januszewski M. D.

, 19 (Address) 2431 Gait Ln

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Holy Cross Cem	10/17 1929
20 UNDERTAKER	ADDRESS
Stephen J. Piatkowski Jr.	1000 S. Kenwood ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Bks.

E 50159

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 E 50159

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 46-1

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Doris Margaret Wilkinson

(a) RESIDENCE NO. 919 So. Bouldin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Maurice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Brookland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct-6, 1929, to Oct-16, 1929

that I last saw h.. alive on Oct-16, 1929

and that death occurred, on the date stated above, at 2 45 a m.

The CAUSE OF DEATH* was as follows:

Miliary TB
Tuberculous meningitis
Tuberculous peritonitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross pm

(Signed) J. T. Bickford Jr., M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Oct. 17 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiber Inc.	402 So. Wolfe St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50160

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50160

38

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Brockschmidt

(a) RESIDENCE NO. 711 N. Collington Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Catherine

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jeriah Brockschmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Antoinette Hilmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed OCT 17 1929, 19 C. HAMPSON JONES, M. D.
per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 29, 19, to Oct. 15, 29, 19.

that I last saw him alive on Oct. 15, 19 29

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic Toxic: Colitis Insufficiency (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. P.C. Wass. Autopsy

(Signed) Warren H. McLean, M. D.

10-16, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct. 19, 1929
20 UNDERTAKER Lilly & Zeiler Inc.	ADDRESS 403 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Blks.

E 50161
22647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50161
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. N 6-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mike Kurpis

(a) RESIDENCE NO. 710 Eastern Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 044

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Jan Kurpis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Leona Maximus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Rentals

(Address) JOHNS HOPKINS HOSPITAL

Filed OCT 17 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-15-1929

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to Oct-15, 1929, that I last saw him alive on Oct-15, 1929 and that death occurred, on the date stated above, at 7.05 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Uremia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute pericarditis,

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? P.M. examination

(Signed) Alexander Preston, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	10/17 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 E Lord Av

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Blks.

E 50162

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50162

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1766 E North ave ST., 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H Johnson

(a) RESIDENCE NO. 1766 E North ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~) of Catherine R Johnson

6 DATE OF BIRTH (month, day, and year) Feb 7th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Bertha Diffendall

(Address) 1766 E North ave

15 Filed OCT 17 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17th 1929

17 I HEREBY CERTIFY, That I attended deceased from October 15, 1929, to October 17 1929, that I last saw h[illegible] alive on October 16, 1929 and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Coronary Insufficiency
Arterial Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Clark Coventry, M. D.

10/17, 1929 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 20th 1929
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument

Spec.—1929-2500 Bks. E 50168

230156

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50163

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Creswell

(a) RESIDENCE NO. Joppa Harford Co Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora

6 DATE OF BIRTH (month, day, and year) 3-23-69

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 081

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed OCT 17 1929 C. HAMPSON JONES, M.D. Registrar

Par ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/15/29, ~~19~~, to 10/16, 1929,

that I last saw ~~him~~ alive on 10/16, 1929

and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Hypertension
Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ludwell Ellsworth, M. D.

10/17, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mountain Cem.	Oct 19 1929
20 UNDERTAKER	ADDRESS
Harnberger & Goods	Baltimore Md.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50164 E 50164

CERTIFICATE OF DEATH.

161-29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp ST. Mtg WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pyles

(a) RESIDENCE NO. Dulwood Pl. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/7/29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James H. Pyles

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Virgie Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant
(Address) Clinical Records

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9-29

17

I HEREBY CERTIFY, That I attended deceased from 10-5-29, 19 , to 10-9-29, 19 ,

that I last saw h alive on 10-9-29, 19 ,

and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

prematurity

(duration) yrs. 4 mos 2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes Annual

What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D.

(Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

(Zerin)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

2E 9927
2E 50165

CERTIFICATE OF DEATH

× 84

E 50165

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther Zerin

(a) RESIDENCE NO. 1865 University Parkway ST. New York WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin

6 DATE OF BIRTH (month, day, and year) July 24, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Konoiko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Hannah Helman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rivals
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17/29

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1929, to Oct 17, 1929, that I last saw her alive on October 17, 1929, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Brain tumor, glioma, benign

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, bronchial

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12 Oct. 29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) E. H. Compton Jr. M. D.

10/17. 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York N. Y	Oct 17 1929
20 UNDERTAKER Aof Gibbons & Bro	ADDRESS 1127 E Balto st

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50166

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hospital 4-20 ST., WARD)

2—FULL NAME Isaiah Thomas

(a) RESIDENCE NO. Glenwood Howard Co. Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	17	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ?

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant [redacted] Father
(Address) Glenwood Md

15 Filed 1 7 1929 C. H. EMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17-29

17 I HEREBY CERTIFY, That I attended deceased from 9-7-29, 19..., to 10-17-29, 19...,

that I last saw h... alive on 10-17-29, 19...

and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of right testicle, Abdominal glands and Lungs

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Geo. McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glenwood Md.	Oct 19 1929
20 UNDERTAKER	ADDRESS
D. Price & Son	Sykesville

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Byerly 3048 ✓ Watch me

E 50167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 50167

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 1564 Moreland ST. 8-16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Ganzhorn

(a) RESIDENCE NO. 1552 Moreland ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert D Ganzhorn

6 DATE OF BIRTH (month, day, and year): Sept 26, 1864

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Samuel Meginney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lucinda Arrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lucinda J Childs

(Address) 1564 Moreland Ave

15 Filed ..... 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 16. 1929

17 I HEREBY CERTIFY That I attended deceased from Oct 14th, 1929, to Oct 16th, 1929, that I last saw h[illegible] alive on Oct 16th, 1929 and that death occurred, on the date stated above, at 2:20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.
Hypertension.
Cardiac insufficiency.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) uraemia

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. P. Byerly, M. D.

, 19 (Address) 3048 Boyce Monument Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral

DATE OF BURIAL: 10/19 1929

20 UNDERTAKER: J. Cook

ADDRESS: 1217 E Fayette St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50168

CERTIFICATE OF DEATH

112 E 50168

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 744 Poplar Grove St., 16-68 Ward)

2-FULL NAME Frank McHardy.

(a) RESIDENCE NO. 744 Poplar Grove St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of NO

6 DATE OF BIRTH (month, day, and year) Oct 23-1878

7 AGE: Years 30 | Months 11 | Days 22 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) 186
(c) Name of employer

9 BIRTHPLACE (city or town) New Orleans La
(State or country)

PARENTS

10 NAME OF FATHER Jas P. McHardy

11 BIRTHPLACE OF FATHER (city or town) Scotland
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Kilbride

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mary E McHardy
(Address) 744 Poplar Grove

15 Filed 17 1929 19 C. HAMPSON JONES M. D. Registrar

RRH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
8 Hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Error of Diet
8 Hours

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) L. Hartluck M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (City) — DATE OF BURIAL 10/18 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 Park Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-14 65-001 E 50169

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 803 McKim St 10-14 Ward)

2-FULL NAME Wm. Johnson

(a) RESIDENCE NO. 803 McKim St., — Ward

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	unknown

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Harriett Johnson

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer do
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Unknown

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Police Records
(Address)

15 Filed 1929 G. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8/29 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Myocardial Failure
(Chr. Lymphoidal Leukemia- Chr Nephritis)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What (es(confirmed diagnosis? Pathology Hopkins Disp
(Signed) ..... M. D.
10/15/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health

OCT 17 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50170

CERTIFICATE OF DEATH

66 E 50170

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1124 Peach Alley. St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Howard.(C)

(a) RESIDENCE NO. 1124 Peach Alley. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow.

5a If married, widowed, ~~XXXXXXXXX~~ ~~XXXXXXXXX~~ (or) WIFE of Burnett Howard.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Elmer Thomas.(C) son.
(Address) 1104 Peach Alley.

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

OCT 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 4, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto Steinhardt, M. D.

10/16. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OCT 1 1929 Commissioner of Health.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Grandison ✓

E 50171 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50171

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 12-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Grandison

(a) RESIDENCE No. 2438 Francis ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14 1928

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Aaron Lemard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lena Grandison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant C. G. Douglas

(Address) Johns Hopkins Hospital

Filed 1929 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-14, 1929, to 10-14, 1929.

that I last saw him alive on 10-14, 1929

and that death occurred, on the date stated above, at 9.20 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Septicaemia (B. Coli)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. G. Douglas M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health

Per Cm E. [illegible]

3971

CAUSE OF DEATH MUST BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Stevenson ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50172

E 50172

38

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6-9 WARD)

2-FULL NAME Baby Stevenson

(a) RESIDENCE NO. 6 N. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, (widowed, or divorced) HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 11 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER William Kent

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ambrose Stevenson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant A. G. Douglas

(Address)

Filed 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-11, 1929, to 10-11, 1929

that I last saw h. alive on 10-11, 1929

and that death occurred, on the date stated above, at 3.20 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

Syphilis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Wassermann Reaction

(Signed) A. G. Douglas, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

OCT 17 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50173 ×50 E 50173

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital ST., 14th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Olive Neff

(a) RESIDENCE NO. Bellaire, Ohio R.F.D # 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Mar~~ 3rd 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44 yrs	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) home-work

(c) Name of employer

9 BIRTHPLACE (city or town) Bellaire, Ohio.
(State or country) Belmont county; R.F.D. #2

PARENTS

10 NAME OF FATHER John W. Neff

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bellaire, Ohio.

12 MAIDEN NAME OF MOTHER Mary McKelvey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bellaire, Ohio

14 Informant Mrs. Elizabeth M. Neff
(Address) Bellaire, Ohio, R.D # 2

15 Filed OCT 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 19 29, to Oct 17, 19 1929

that I last saw h~~e~~r alive on Oct 17, 16:55 A~~M~~ 29

and that death occurred, on the date stated above, at 11; AM m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism 17 days following operation for removal of extra peritoneal abdominal cyst (25 mm.)

(duration) ~~yrs. mos. ds.~~

CONTRIBUTORY (Secondary) Abdominal cyst adv. noted 3 mo. ago (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Yes Date of Oct 3rd 1929

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas G Hardyce M. D.

, 19 (Address) Womans Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethlehem Bellaire Ohio	Oct 19 19 29
20 UNDERTAKER Stewart & Mowen Co	ADDRESS 808 Main

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Blks.

Anthony • Muscicwujewski

E 50174

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50174

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Baltimore City Hosp., ST. 3-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Muscicwujewski

(a) RESIDENCE NO. 613 S. Dallas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Muscicwujewski

6 DATE OF BIRTH (month, day, and year) June 15 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Muscicwujewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Rose ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record
(Address)

15 Filed OCT 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16/29

17 I HEREBY CERTIFY, That I attended deceased from 10/10, 1929, to 10/16, 1929

that I last saw him alive on 10/16, 1929

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma lower 1/3 oesophagus —

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Coronary Embolism

(duration) yrs. mos. ds. 1/2 hr

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, X ray.

(Signed) L. A. Crumpler, M. D.

10/16, 1929 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary cem	Oct 19 1929
20 UNDERTAKER	ADDRESS
John H Weber	401 S Chester st

Spec.—2-29-28—L. P. S.—600 Blks.

29/30175

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 50175

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-11 WARD)

2—FULL NAME Dorothy Camella Thompson

(a) RESIDENCE NO. 513 N. Potomac ST., St- WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/3/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5-	1 2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md-

PARENTS

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md-

12 MAIDEN NAME OF MOTHER Mad[illegible] Cisa Buchanan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md-

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Oct 16, 1929.

that I last saw her alive on Oct 16, 1929

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

(malnutrition, rickets, convulsions, ammia) bronchial pneumonia.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Idiocy

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

10/17, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem Oct	19 1929
20 UNDERTAKER	ADDRESS
John C. Miller 2435 E Alice	20

Spec.—2-29-28—L. F. H.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50176

CERTIFICATE OF DEATH

57 E 50176

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3533 Belvedere Ave. ST. 27-36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Anna Griffith

(a) RESIDENCE NO. 3533 Belvedere Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Griffith

6 DATE OF BIRTH (month, day, and year) April 7, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

037

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Schumacher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Nurnburger

13 BIRTHPLACE OF MOTHER (city or town) White Plains
(State or country) New York

14 Informant Mr. Albert N. DeHoff
(Address) 4976 Edgemere Ave.

15 Filed OCT 17 1929 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Oct 15, 1929, that I last saw her alive on Oct 14, 1929 and that death occurred, on the date stated above, at 4.25 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) [illegible], M. D.

Oct. 19 29 (Address) 517 Scott Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct. 18 19 29
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 West Baltimore St

Cor.—12-9-25—A Co.—200 Bks.

E 50177.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188 E 50177

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital) 22-30 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lawrence B. Carlin

(a) RESIDENCE NO. 808 W. Barre St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda Carlin

6 DATE OF BIRTH (month, day, and year) July 21, 1899

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	30	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Works

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bartlett-Hayward

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence Carlin

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Minne Weincker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr. Mathew Carlin

(Address) 808 W. Barre St.

Filed 11 1929 C. HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull

auto in which he was a rider collided with pole & route from Bed

(duration) yrs. mos. ds.

Due CONTRIBUTORY (Secondary) Fract L. Femur

Traumatic Shock (duration) yrs. mos. ds.

(Signed) H. H. Faust M. D.

10/16 1929 (Address) (Coroner) 2939 McElderry Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Monument & Durham Sts

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Oct. 18 1929

20 UNDERTAKER Joseph H. Cook ADDRESS 1003 West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50178

E 50178

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 25-72 Ward)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Woodey

(a) RESIDENCE NO. 2315 James St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Woody

6 DATE OF BIRTH (month, day, and year) Nov. 9 - 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	72	4	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Sterling Bros 630
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Howard Woody
(Address) 2315 James St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/17. 19 29 (Address) 2 E Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	10/14 1927
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. HAMPSON JONES, M.D.

RRR

17 1929

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50179

CERTIFICATE OF DEATH.

90E 50179

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 304 Lorraine av St. 12-50 Ward)

2-FULL NAME John Moylan

(a) RESIDENCE NO. 304 Lorraine av St._____ Ward_____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/15/1870

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	58	11	1	X

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER John Moylan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Tuite

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs Fanny Moylan
(Address) 304 Lorraine

15 OCT 7 1929 19 RKS Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal Paralysis of Heart
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) John Morrison M. D.
10/6, 1929 (Coroner) (Address) 1672 Poland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Date of Burial 10/8/1929

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

2E 29408
2E 30180

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 84 ✓ E 50180

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2—FULL NAME Edna A. Starcher

(a) RESIDENCE NO. Huntington W. Va ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. W.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER U. S. Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Records

(Address) JOHNS HOPKINS HOSP.

15 Filed 1 8 1929, 19 E.S.J. Registrar C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1927, to Oct 18, 1929, that I last saw her alive on Oct 18, 1929 and that death occurred, on the date stated above, at 1:0 A m.

The CAUSE OF DEATH* was as follows:

Brain tumor, Benign

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 27

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) E H Compton Jr, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Huntington W. Va	Oct 18 19 29
20 UNDERTAKER John O. Mitchell Son	ADDRESS Hun

Important. See instructions on back of Certificate

Cor.—10-10-29—A Co.—100 Bks.

E-50181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 E-50181

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals St. 13-52 Ward)

2-FULL NAME Matthew A. Gillard

(a) RESIDENCE NO. 3519 Ash St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Gillard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Martin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Capt. Packard
(Address)

OCT 18 1929 C. HARRISON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture R. femur struck & knocked down by auto in front of 3539 Falls Rd

CONTRIBUTORY (Secondary) Pneumonia (Hypostatic) (duration) yrs. mos. dys.

18 Where was disease contracted if not at place of death? in front of 3539 Falls (duration) yrs. mos. ds.

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) L. D. Frame, M. D.

10/18 1929 (Address) 2939 W. Eds

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hayward | DATE OF BURIAL 10/19 1929

20 UNDERTAKER Wm. Marshall | ADDRESS 3537 Falls Rd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50182

CERTIFICATE OF DEATH

90 E 50182

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1531 Madison Ave (St.) 44-30 (WARD)

2—FULL NAME John Carney

(a) RESIDENCE NO. 1531 Madison Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Harry Leonard

(Address) 1623 E. Baltimore St

15 Filed OCT 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Oct 15, 1929, that I last saw h in alive on Oct. 14, 1929 and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis & Valvular disease (duratinn) not known yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Phys. exams

(Signed) Chas. Keller, M. D.

Oct 17 1929 (Address) 2226 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery New York

DATE OF BURIAL Oct 18 1929

20 UNDERTAKER [illegible]

ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Blks.

E 50183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 50183

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Baltimore Md. 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isadore Hymowitz

(a) RESIDENCE NO. 1503 St. Emallwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Mary Hymowitz

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 35 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Solomon Hymowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rebecca Segel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mary Hymowitz (Address) 1503 St. Emallwood

15 Filed . . 19 . . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/17 1929

17

I HEREBY CERTIFY, That I attended deceased from 10/16/29. 19 . to 10/17 . 1929.

that I last saw h alive on 10/17/ . 1929.

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Sarcomatosis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Gut. Examination.

(Signed) B J Cohen M. D.

10/17. 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 10/18 1929

20 UNDERTAKER: Jack Laus — ADDRESS: 1429 E Balto St

CAUSE OF DEATH in plain terms. So that it may be properly classified. Last statement of Dr. [illegible]

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8A E 50184

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 711 S. Glover ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CAROLINE NORWOOD

(a) RESIDENCE NO. 711 S. Glover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Norwood

6 DATE OF BIRTH (month, day, and year) July 17, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER ? Philips

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Warner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant MR. Charles A. Norwood (Husband)
(Address) 711 S. Clover St.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1927, to Oct 17, 1929 that I last saw her alive on Oct 10, 1929 and that death occurred, on the date stated above, at 2.25 a. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Rev. H. Feller M. D.

10.18.1929 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Matthew's Cemetery	Oct. 20 1929
20 UNDERTAKER Henry Sander & Sons Inc.	ADDRESS BALTIMORE ST. & BROADWAY

Spec.—2-29-28—L. F. S.—500 Bks.

E 50185 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50185

CERTIFICATE OF DEATH

X 111-002

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Bon Secours Hospital St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph R. Taney

(a) RESIDENCE NO. Pikesville St. Md. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married.

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of ~~(or) WIFE of~~ Lydia Fleury Taney

6 DATE OF BIRTH (month, day, and year) Sept 27th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph R Taney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER C. L. White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant John R. Taney

(Address) Cockeysville Md.

15 Filed OCT 18 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/29

17 I HEREBY CERTIFY, That I attended deceased from 10/12, 1929, to 10/18, 1929, that I last saw h~~im~~ alive on 10/18, 1929 and that death occurred, on the date stated above, at 12 20 a.m.

The CAUSE OF DEATH* was as follows:

Massive collapse of base of left lung - (or infarct)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Duodenal ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 10/14/29

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Theo E Stacy Jr. M. D.

. 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stephens Upper Falls Balto Co	Oct 19 1929
20 UNDERTAKER	ADDRESS
Geary & Jenkins Co Inc	Oakland Md Garrett Co

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 118-002 ✓

L 50186

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 1630 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Robins Douglas

(a) RESIDENCE NO. Annapolis ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry T. Douglas

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila - Pa.

PARENTS

10 NAME OF FATHER Edward Robyns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila - Pa

12 MAIDEN NAME OF MOTHER Margaret Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant Elizabeth Robins Pennell

(Address) 449 Parkway N. Y. City

OCT 18 1929 FILED W. HAMPSON JONES, M. D.

Filed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15th, 1929, to Oct 17, 1929, that I last saw HER alive on Oct 17th, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal obstruction

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Draper, M. D.

10-17-1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 19 1929
20 UNDERTAKER	ADDRESS
Lewis Jenkins & Son	Cathedral & Mt. Vernon Pl

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50187

CERTIFICATE OF DEATH

90 E 50187

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Temple Garden ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Israel Spicer

(a) RESIDENCE NO. Temple Garden ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sara

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Financier

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country) Austria

PARENTS

10 NAME OF FATHER Hungary Hermann

11 BIRTHPLACE OF FATHER (city or town) Austria

(State or country) Russia

12 MAIDEN NAME OF MOTHER Bella Farber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Mrs. Spicer

(Address) 1515 Eutaw Place

Filed OCT 1 9 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to Oct 18, 1929, that I last saw h[illegible] alive on Oct 18, 1929 and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH was as follows:

Mitral Stenosis & Aortic Regurgitation

(duration) 44 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Phys. Examination

(Signed) Harry Goldberg, M. D.

10/18, 1929 (Address) 2210 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL Oct 18 1929

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

Spec.—2-29-28—L. F. S.—500 Blks.

E 50188

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50188

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 16-139

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Thiess

(a) RESIDENCE NO. 3528 Noble st. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in whirh employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Theiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary McNaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed OCT 18 1929 C. HAMPSON JONES, M.D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1929, to Oct. 16, 1929,

that I last saw him alive on Oct. 16, 1929

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Thos. Thiess M.D.

10-17 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Oct 19 29
20 UNDERTAKER	ADDRESS
Mrs E Miller & Son	2334 Jefferson St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50189 +1084 E 50189

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md. ST. 76-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Faist

(a) RESIDENCE NO. 23 Admiral Blvd. ST. WARD
(Usual place of abode) Dundalk Md.
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...laborer

(b) General nature of industry, business, or establishment in which employed (or employer) mill worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospitals
(Address) Baltimore

Filed 10 8 1929 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-17-29

17 I HEREBY CERTIFY, That I attended deceased from 10-12-, 1929, to 10-17, 1929

that I last saw h. alive on 10-17, 1929

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure
Acute Tonsilitis

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically Autopsy

(Signed) Henry G. Dorsett M. D.

10/17 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemt.	Oct 20 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	407 S. Wolfe St

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50190

CERTIFICATE OF DEATH

90 ✓ E 50190

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Enroute Hopkins Hospital St. 27-42 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Glock

(a) RESIDENCE NO. 4203 Springwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Glock

6 DATE OF BIRTH (month, day, and year) Mar 8/1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	59	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Glock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Rauh

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Elizabeth Glock
(Address) 4203 Springwood Ave

15 Filed ..... 19 C. HAMPSON JONES M. D. Registrar

10/8 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion 4 days before (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History by Family Dr

(Signed) J. H. Cullen, M. D.

10/17/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Oct 19 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	403 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50191

CERTIFICATE OF DEATH

129 E 50191

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3504 Clairmount ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marian Celozzi

(a) RESIDENCE NO. 3504 Clairmount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Celozzi

6 DATE OF BIRTH (month, day, and year) Nov. 21st 1888

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER John Celozzi

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Louise Dinunzio

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Anthony Celozzi (husband)
(Address) 3504 Clairmount Ave.

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16/29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1- 1929, to Oct 15 1929, that I last saw her alive on Oct. 15 1929 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis, Chronic interstitial

(duration) yrs. 6+ mos. ds.

CONTRIBUTORY (Secondary) Valvular disease, Cardiac Chronic (nature)

(duration) yrs. 6+ mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) A. Scotti, M. D.

10/16, 1929 (Address) 1117 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Oct 19 1929
20 UNDERTAKER Lilly & Gaither Inc	ADDRESS 400 E. Mosher St

Spec.—1-10-21—MAT—1500 Blks.

E 50192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 E 50192

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 6 Y WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schmuckler

(a) RESIDENCE NO. 1737 E. Fairmount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Schmuckler

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1437 E Baltimore St

15 Filed OCT 8 1929, 19.. H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18 1929

17

I HEREBY CERTIFY, That I attended deceased from 10/4, 1929, to 10/18, 1929, that I last saw h[illegible] alive on 10/18, 1929, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertrophied Adenoids

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 10/15/29

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Exam.

(Signed) L. L. Silver M. D.

10/18 1929 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Carmel — DATE OF BURIAL 10/21 1929

20 UNDERTAKER Jack Lewis — ADDRESS 1437 E Balto St

CAUSE OF DEATH must be properly classified. Each statement of OCCUPATION on back of certificates. That it may be properly classified, so that TION is very important. See instructions

Spec.—1-10-21—M&T—1500 Bks.

E 50193 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 74-002 E 50193

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ..... ST 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sydney Cohen

(a) RESIDENCE NO. 717 Aisquith St

(Usual place of abode) ST., ... WARD .....

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Abe Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Hellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abe Cohen

(Address) 717 Aisquith St

15 Filed OCT 18 1929 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 11 . 1929 . to Oct 18 . 1929.

that I last saw h/s/1 alive on Oct 18 . 1929.

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Furuncle of Nose

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cavernous Sinus Thrombosis Bilateral Septicemia Staph. aureus hemol

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11 11 29

Was there an autopsy? No

What test confirmed diagnosis? Blood culture & clinical

(Signed) Benj H Katz M. D.

10/18 1929 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Nursery Rd	10/18 1929
20 UNDERTAKER	ADDRESS
Jack Levin	1402 E Balt

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50194

CERTIFICATE OF DEATH

161-001

E 50194

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1415 Carey ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ben name of Baby Slater

(a) RESIDENCE NO. 1415 Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-16-29

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unplaced

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Albert Slater

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER: Jane Slater

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md

14 Informant: Jane Slater

(Address): 1514 W Lexington

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

10 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16-29

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

(a) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. J. Peters, M. D.

, 19 (Address) 1631 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS

OCT 18 192

Spec.—1-12-23—M&T—500 Bks.

E 50195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 50195

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 322 N Schroeder ST. 18-26 WARD)

2-FULL NAME Clarence H. Williams

(a) RESIDENCE NO. 322 N. Schroeder ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~the WIFE of~~ Katie R Williams

6 DATE OF BIRTH (month, day, and year) 2/27/[illegible]

7 AGE	Years	Months	Days	If less than 1 day, ... hrs. or ..... min.
	[illegible]	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer) Of

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Maurice Williams

11 BIRTHPLACE OF FATHER (city or town) Balto Co. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Williams

13 BIRTHPLACE OF MOTHER (city or town) Phila Pa
(State or country)

14 Informant (Address) Margaret Williams 322 N Schroeder St.

15 Filed 10 8 1929 G. HUMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to October 17th 1929, that I last saw h[illegible] alive on October 15th, 1929, and that death occurred, on the date stated above, at 12.10 a m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Disease

(duration) Unknown yrs.

CONTRIBUTORY .....
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. F. Howell M. D.

(Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 10-20 1929

20 UNDERTAKER Gal. Inc. Skinner — ADDRESS 1620 D. Madison

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50196 E 50196

CERTIFICATE OF DEATH

164

1—PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1841 No. North Ave WARD 15-47)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac C'Neill

(a) RESIDENCE NO. 1841 No. North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. da. How long in U. S., if foreign birth? 72 yrs mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas C Neill

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Kilkenny
(State or country) Ireland

PARENTS

10 NAME OF FATHER James Burns

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Grace

12 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Eliz Carey
(Address) 1841 N. North Ave

15 Filed 10 1 1929 19 C. HAMPSON JONES, M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17/29

17 I HEREBY CERTIFY, That I attended deceased from August 1st 1929 to October 17 1929

that I last saw her alive on October 17th 1929

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion
(Old age)

..... (duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Amelia E. Smith, M. D.

10/21 1929 (Address) 1717 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cath Cem	10-21 1929
20 UNDERTAKER D. J. Rush	ADDRESS 640 S. Eutaw

Spec.—1-10-21—M&T—1500 Bks.

E 50197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 50197

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5907 Belair Road ST. (Ward)

2-FULL NAME Elizabeth C. Manfuso

(a) RESIDENCE No. 5907 Belair Road ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gaetano Manfuso

6 DATE OF BIRTH (month, day, and year): March 17-1874

7 AGE: Years 55 Months 7 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jasmed Barsatti

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Maria Buraschi

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: G. Manfuso (Address): 5907 Belair Road

15 Filed: OCT 18 1929 Registrar: C. H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1929, to Oct. 16, 1929, that I last saw h[illegible] alive on Oct. 16, 1929, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma Rectum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Insomnia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) C. Horton Smith M. D.

10/18, 1929 (Address) 817 Park Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery DATE OF BURIAL: 10/19/1929

UNDERTAKER: Chas. S. Manelson ADDRESS: 1130 W. Royal Ave

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50198

CERTIFICATE OF DEATH

90 ✓ E 50198

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1907 E. Fairmale ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna E. Hirzel

(a) RESIDENCE NO. 1907 E. Fairmale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John H. Hirzel

6 DATE OF BIRTH (month, day, and year) Jan 22-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	77	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo Stoeker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant John H Hirzel
(Address) 1907 E. Fairmale

15 Filed OCT 18 1929, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17-1929

17

I HEREBY CERTIFY, That I attended deceased from October 1, 1929, to October 17, 1929,

that I last saw h.. alive on October 17, 1929

and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A. H. Mayer, M. D.

Oct 19, 1929 (Address) 2131 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 19 1929
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 50199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 50199

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1346 E. Fort Ave 24-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse M. Garnette

(a) RESIDENCE NO. 1346 E. Fort Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Evans

6 DATE OF BIRTH (month, day, and year): July 22 1871

7 AGE: Years 57 | Months 7 mos. | Days 15 ds. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B & O. Ry.

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Garnette

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Elizabeth Garnette

(Address) 1346 E. Fort Ave

15 Filed 1 8 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 16. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 16, 1929, that I last saw h alive on Oct 16, 1929 and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Uremic Nephritis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. J. Hopkins M. D.

10/16 1929 (Address) 16 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	10-18 1929
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	Hanover St

Spec—12-23-21—F.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50200

CERTIFICATE OF DEATH.

129

E 50200

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2727 Mosher St. 16-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Henry W. Blake Jr.

(a) Residence No.... 2727 Mosher St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 14 1855

7-AGE 74 yrs. 3 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Cabinet Hard Wood finisher

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, H. Blake

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, ~

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ~

14- (Informant) Mrs. H. W. Blake

(Address) 2727 W. Mosher st

15- Filed 10 18 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH (month, day and year) Oct 16-29

17- I HEREBY CERTIFY, That I attended deceased from Aug 28 1929 to Oct 16 1929, that I last saw him alive on Oct 14 1929, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John D. Pitts M. D.

10/18 1929 (Address) 736 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet DATE OF BURIAL. 10-19-1929

20-UNDERTAKER, H. Brauning Son ADDRESS 1136 Pulton Ave

Instructions on back of certificates.

1 81929

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Montgatwyd. 29 N Carey St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50201

CERTIFICATE OF DEATH

47

E 50201

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1454 Montpelier ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Harrison

(a) RESIDENCE NO. 1454 Montpelier ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Harrison

6 DATE OF BIRTH (month, day, and year) Nov 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	48	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Manchester
(State or country) Va

PARENTS

10 NAME OF FATHER William Meredith

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant William Harrison
(Address) 1454 Montpelier

15 Filed 1 8 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 29th, 19 29, to Oct 17th, 19 29
that I last saw h— alive on Oct 16th, 19 29
and that death occurred, on the date stated above, at 4 9 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Exam.

(Signed) Henry Hampson Jones M. D.

10/18/1929 (Address) 401 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 10/19/1929

20 UNDERTAKER H. Cook

ADDRESS 1217 E Cold St

Cor.—10-10-29—A Co.—100 Bks.

E 50202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001 ✓ E 50202

1-PLACE OF DEATH

City of Baltimore: (No. 2019 W. Baltimore St. 10-28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Anna V. Smith

(a) RESIDENCE NO. 2019 W. Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Millard J Smith

6 DATE OF BIRTH (month, day, and year) Nov 8 1886

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
42	11	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Ellicott Knable

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Knable

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Millard J Smith
(Address) 2019 W Baltimore

15 Filed ....., 19.... C. HUMPSON JONES, M. D. Registrar

OCT 19 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide by Illuminating Gas Asphyxiation

(duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Braun M. D.

Oct 17 1929 (Address) 3601 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	10/19 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

De Marco / Med Exs

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50203

CERTIFICATE OF DEATH

129 E 50203

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 769 Carroll (ST.) 21-29 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas A. Helmling

(a) RESIDENCE NO. 769 Carroll ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Helmling

6 DATE OF BIRTH (month, day, and year) July 16. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Amelia Helmling

(Address) 769 Carroll St

15 Filed 10 8 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16. 1929

17

I HEREBY CERTIFY, That I attended deceased from 9-12-, 1929 to 10-16, 1929

that I last saw him alive on 10-16, 1929

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Primary Arteriosclerosis with hypertension, chronic nephritis & Valvular insufficiency (heart) ? (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) acute cardiac dilatation

(duration) ... yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. C. Demarco M. D.

10-18. 1929 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	10/19 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Important: See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Blks.

Anna Morgan

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50204

CERTIFICATE OF DEATH.

118-082

E 50204

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 27-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Morgan

(a) RESIDENCE NO. 2810 Grindon Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Maurice Morgan

6 DATE OF BIRTH (month, day, and year) Aug. 23, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	1	25	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Heinrich Hofner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Maurice C Morgan (Address) 2810 Grindon Ave

15 Filed OCT 18 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1929, to Oct 16, 1929,

that I last saw he alive on Oct 16, 1929,

and that death occurred, on the date stated above, at 5:15 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Oct 17, 1929

What was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Young, M. D.

Oct 18, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 10/21 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

TION is very important See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 50205

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50205

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 441 E. 27th. St.; Ward 12-50)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys Hess

(Residence in Baltimore: No. 441, E. 27th. St.; ....yrs,.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, April 12, 1907
(Month) (Day) (Year)

7-AGE, 22 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cashier
(b) General nature of industry, business, or establishment in which employed (or employer): L. Hoffberger & Sons Inc

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Joseph C Hess

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Edith M Jones

13-BIRTHPLACE OF MOTHER (State or Country) Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith M Hess

(Address) 441 E 27th St

15-

Filed ....., 191.....

C. HAMILTON JONES, M. D.
Registrar.

1 81929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 17th., 1929
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1927, to Oct. 17th. 1929, that I saw her alive on Oct. 10th 1929, and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Syncope

(Duration) ....yrs. ....mos. 5 ....ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 2 yrs. 6 mos. ....ds.

(Signed) H. M. Gillenwater M. D.

Oct 18, 1929 (Address) 415 Cedarcroft Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, 10/19, 1929

20-UNDERTAKER J M Cook — ADDRESS 1211 E Fond St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50206

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 N. Caroline ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Hecht

(a) RESIDENCE NO. 1819 N Caroline ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Eliza E. Hecht

6 DATE OF BIRTH (month, day, and year) Feb 22-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Water Dept.

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Eliza E. Hecht

(Address) 1819 N. Caroline St.

15 Filed ..... 19 .....

1 8 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1928. to Oct 18. 1929.

that I last saw h alive on Oct 18 1929

and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertensive Cardio-vascular renal disease (duration) 20(?) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical study

(Signed) Frederic V.D. Wack, M. D.

, 19 (Address) 827 N Charles ST

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/21 1929
20 UNDERTAKER	ADDRESS
Chas. P. Maus & Son	118 W Mt Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50207

CERTIFICATE OF DEATH

129 E 50207

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 8 E. Fort Ave. ST. 23-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Stanton

(a) RESIDENCE NO. 8 E. Fort Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L.W. Stenton.

6 DATE OF BIRTH (month, day, and year) March, --1853.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76.	7.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Casper Whitter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14

Informant A. Laura Wisenauer.

(Address) 8 E. Fort Ave.

15

Filed OCT 21 1929, 19 ..... HENDERSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/29

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 18, 1929, that I last saw h[er] alive on Oct. 18, 1929 and that death occurred, on the date stated above, at 3.30 P.m.

The CAUSE OF DEATH* was as follows:

Arteio sclerosis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Lucas M. D.

10/18. 1929 (Address) 448 E Fort Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Oct 21, 1929
20 UNDERTAKER	ADDRESS
C. Howard Evans	35 E. Fort Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50208

1—PLACE OF DEATH

CERTIFICATE OF DEATH

90 ✓ E 50208

REGISTERED NO.

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSP ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie Holland

(a) RESIDENCE NO. 1531 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) ? 021

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Md.

PARENTS

10 NAME OF FATHER Robert H. Hare

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER Mary E. Dorsey

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant Records
(Address) BALTIMORE CITY HOSPITALS

15 FILED OCT 19 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16-29

17 I HEREBY CERTIFY, That I attended deceased from 6-16, 1926, to 10-16, 1929

that I last saw her alive on 10-16, 1929

and that death occurred, on the date stated above, at 3 20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Interstitial

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.C.

(Signed) Harris M. McLean, M. D.

Oct, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	Oct 20 1929
20 UNDERTAKER John W. Henderson	ADDRESS 1832 E Monument St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50209

CERTIFICATE OF DEATH

129 ✓

E 50209

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 306 E Washington ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Rubl

(a) RESIDENCE NO. 2214 E Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Daniel B Rubl

6 DATE OF BIRTH (month, day, and year) February 7th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Armeling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Daniel B Rubl

(Address) 2214 E Biddle st

15 Filed OCT 19 1929, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/29

17 I HEREBY CERTIFY, That I attended deceased from 5/15/, 1927, to 10/18/, 1929,

that I last saw her alive on 10/12/, 1929,

and that death occurred, un the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

Myocarditis

Hypertension (duration) History 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy (duration) Immediate yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard J. Terry, M. D.

10/19/1929 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Oct 21st 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

Spec.—2-29-28—L. P. S.—500 Blks.

E 50210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94-001

E 50210

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4708 Park Heights Ave ST. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Frederick Scott,

(a) RESIDENCE NO. 4708 Park Heights Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 11 mos. 19 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

6 If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~ Helen T. Scott,

6 DATE OF BIRTH (month, day, and year) October 31. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0 31

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frederick T. Scott,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Cook,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Helen T Scott

(Address) 4708 Park Heights Ave

15 Filed OCT 19 1929 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 4. 1929 to Oct 19 1929

that I last saw him alive on Oct 19 1929

and that death occurred, on the date stated above, at 2.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 10 ds.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Dubert M. D.

. 19 (Address) 4754 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	19
20 UNDERTAKER Geo W Little	ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50211

CERTIFICATE OF DEATH

74-001 E 50211

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1928 Aleays ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alverda Livingston

(a) RESIDENCE NO. 1928 Aleans ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Apr 18 54

7 AGE: Years 75 | Months 5 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Lorenzo D Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Isabelle Riddick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Annie Cunningham

(Address) 3019 W. North Ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 17 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 19 24 to Oct 17, 19 29

that I last saw h[illegible] alive on Oct 17, 19 29

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Koval, M. D.

(Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk

DATE OF BURIAL: Oct 21, 19 29

20 UNDERTAKER: Philip Herwig

ADDRESS 2019 Aliceanna St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 ✓ E 50212

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Milton Ave ST., 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Fahey

(a) RESIDENCE NO. 1117 N. Milton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: John Fahey

6 DATE OF BIRTH (month, day, and year): Apr 7/82

7 AGE: Years 47 Months 6 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Chas. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lena Worsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Fahey

(Address): 1117 N. Milton Ave.

15 Filed 1929 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 29 Oct 18 29, 19..

that I last saw h... alive on Oct 16 29

and that death occurred, on the date stated above, at 12:35 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of May

Was there an autopsy? No

What test confirmed diagnosis? Postmortem

(Signed) J. Dec Ricker M. D.

(Address) 800 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: Oct 21 1929

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St

Spec.—1-10-21—M&T—1500 Blks.

Draves.

E 50213

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50213

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10-14 ST., WARD)

2-FULL NAME Lucrecia Daroes

(a) RESIDENCE No. 1009 Somerset ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Francis Paul Darone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Maggio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Francis Paul Darone
(Address) 1009 Somerset st

15 Filed , 19 Registrant

OCT 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Oct 17, 1929, that I last saw her alive on Oct 17, 1929, and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Infantile Decubitus Pneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benjamin Cohen, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Oct 19 1929

20 UNDERTAKER Frank V. Parkinson

ADDRESS 2015 E. Balto st

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50214

CERTIFICATE OF DEATH

185 ✓

E 50214

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 6-11 Ward)

2-FULL NAME Wm E Compers

(a) RESIDENCE NO. 24 N Han St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Divorced

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Crispens

6 DATE OF BIRTH (month, day, and year) March 25

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	42	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work asst Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible] $6
(c) Name of employer Wicaba Co.

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm H. Crispens

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ella Ruark

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Lillian V. Crispens
(Address) 1436 Eastern

15 Filed ....., 19.... W. HAMILTON JOHNS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Abc Fall down Steps
Fracture of Skull Instant
(Duration) yrs. mos. da.
CONTRIBUTORY (Secondary) Shock Instant
(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? — at Home

Did an operation precede death? — Date of —

Was there an autopsy? No

What lesion confirmed diagnosis? Exp & Findings

Signed Wm E Gladden M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	10/19 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 E Pratt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 50215

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50215

100-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hop. ST. 3rd [illegible] to 22nd-5th (W. or E.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Howard Carlton

(a) RESIDENCE NO. 222 Oakdale Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Marshall.

6 DATE OF BIRTH (month, day, and year) June 26, 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	79	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Official Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) (State or country) Peoria N. Y.

PARENTS

10 NAME OF FATHER Mr. Granby Carlton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Buffalo N.Y.

14 Informant Hospital Chart.

(Address)

Filed OCT 19 1929 C. HAMPSON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to Oct 18, 1929, that I last saw h. alive on Oct 17, 1929, and that death occurred, on the date stated above, at 9:45a. m.

The CAUSE OF DEATH* was as follows:

Benign prostatic hypertrophy.

Uremia & bronchopneumonia

a. following suprapubic cystotomy (duration) 1 yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Uremia & pneumonia. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Oct 3, 1929.

Was there an autopsy? No.

What test confirmed diagnosis? Physical examination

(Signed) C.K. Cumpston M. D.

10/15, 1929 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct 19, 1929.
20 UNDERTAKER	ADDRESS
Stewart & Co.	108 W. Mad.

Spec.—2-29-28—L. F. S.—800 Blks.

E 50216

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50216

91-002

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Timothy O'Connell

(a) RESIDENCE NO. Preston + Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) d

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John O'Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridgit Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston + Valley Sts

15 Filed OCT 9 1929 C. HAMPSON JONES, H

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 18, 1929, that I last saw h alive on Oct 17, 29 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs 2

(duration) 5 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Greenwood, M. D.

Oct 19, 29 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Oct 9 1929
20 UNDERTAKER	ADDRESS
Edw Wiedefeld	914 Gruumt Ave

Spec.—2-29-28—L. F. S.—600 Blks.

B 50217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

REGISTERED NO. E 50217

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Corbin Durham

(a) RESIDENCE NO. 1004 N Gustavus ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Elizabeth Durham

6 DATE OF BIRTH (month, day, and year) May 3-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER John Durham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Bone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 31 1929, 19 C. HAMPSON JR. JOHNS, by Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-17-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1929, to Oct 17, 1929, that I last saw him alive on Oct 17, 1929 and that death occurred, on the date stated above, at 11:0 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 36 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy

(duration) 2 yrs + mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? E

(Signed) E. C. James, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westwood Cemetery	Oct 31st 1929
20 UNDERTAKER Kirkwood & Lord	ADDRESS 1723 W Lafayette Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50218 HEALTH DEPARTMENT—CITY OF BALTIMORE 24 Look E 50218

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 14-20 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Moton

(a) RESIDENCE NO. 1605 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ?yrs. ?mos. ? ds. How long in U. S., If foreign birth? – yrs. – mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Private clocker

(b) General nature of industry, business, or establishment in which employed (or employer) 0 & b

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Adam Moton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of
(Address) Balto. City Hospitals

Filed CT 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1929, to Oct. 18, 1929, that I last saw him alive on Oct. 18, 1929, and that death occurred, on the date stated above, at 1:55 A. m.

The CAUSE OF DEATH* was as follows:

Hemorhage into cerebrum

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Nursery & Child's Hospital. Saturday in hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General exam.

(Signed) Lillie Lumpkin, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Oct 20 1929
20 UNDERTAKER Samuel A. Hensley	ADDRESS 1700 E Biddle

Spec.—8-16-29—L. F. S.—100 Bks.

E 50219

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50219

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 713 N. Carey St. 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest Hopkins

(a) RESIDENCE NO. 713 N. Carey ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE — Years: 71 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Eastern Shore Md

PARENTS

10 NAME OF FATHER: Wash. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talbot Co Md

14 Informant: Norman Thomas

(Address) 713 N Carey St

15 Filed OCT 19 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Oct 16, 1929, that I last saw him alive on Oct 16, 1929 and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Whalley, M. D.

Oct 17, 1929 (Address) 1220 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Oct 19 29

20 UNDERTAKER: Samuel Hanley — ADDRESS: Belle

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 50220

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50220

801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N. Durham St 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Artis Jr.

(a) RESIDENCE NO. 414 N. Durham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER James H. Artis Sr.

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Estella Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant James H. Artis Sr. (Address) 414 N. Durham St

Filed OCT 19 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929, to Oct 18, 1929, that I last saw her alive on Oct 18, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C B LeCompte, M. D.

, 19 (Address) 814 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury.	Oct 19 1929
UNDERTAKER Robt. Williams	ADDRESS 1512 McCulloh St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50221

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50221

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 129

CITY OF BALTIMORE: (No. 264 S. Bouldin ST. 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernstine Grannece

(a) RESIDENCE NO. 264 S. Bouldin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Grannece

6 DATE OF BIRTH (month, day, and year) Dec. 23. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Jacob Gerding

(Address) 305 S. Highland Ave

15 Filed OCT 19 1929 T. THOMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Oct 18, 1929, that I last saw her alive on Oct 17, 1929 and that death occurred, on the date stated above, at 12-30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Howard B. Sellman, M. D.

10/18, 1929 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Oct 20 1929
20 UNDERTAKER: George W. Zinkler	ADDRESS: 1737 E. Eager St.

Cor.—10-10-29—A Co.—100 Bks.

E 50222

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50222

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 5-8 Ward)

2-FULL NAME Harry Williams

(a) RESIDENCE NO. 1446 Colvin St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Della Williams

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer F. A. Davis Co.

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine Tate

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Estelle Pritchett
(Address) 706 W. Lanvale

15 Filed OCT 19 1929 HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

(a) Lobar Pneumonia

CONTRIBUTORY (Secondary) (b) Myocarditis (duration) yrs. mos. 1 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Blades M. D.

. 19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	10-20 19 29
20 UNDERTAKER	ADDRESS
Byron Wright	1218 N. Caroline

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50223 Hoppe

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50223

CERTIFICATE OF DEATH

9 126

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary St. 7-10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick George Hoppe

(a) RESIDENCE NO. 2525 E. Monument St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26/1888

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	41	0	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Molder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Frederick T. Hoppe

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret M. Leidig

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Margaret M. Hoppe
(Address) 2525 E. Monument St

15 Filed ... 19 ... Howard Jones, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
General Peritonitis (Pus)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 18/29

Was there an autopsy? No.

What test confirmed diagnosis? Operation for ap-

(Signed) J. H. Pace, M. D.

10/19/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Oct 21 1929
20 UNDERTAKER Jos Jourdens Son	ADDRESS 2178 Pa Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Co. 10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50224 ✓ 74-001 E 50224

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Comfort station L. Wash St St 15-21 Ward)

2-FULL NAME Governor Hayes

(a) RESIDENCE NO. 1712 N. Gilmor St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bonnie Hayes

6 DATE OF BIRTH (month, day and year) 1883 - Mar 14

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
46	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) H. K. Ferguson Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Addie Cox
(Address) 1412 Gilmor St

15 Filed ....., 192... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 10 th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

General Arterio Sclerosis.
Hypertrophy & Dilatation of Heart.
Coronary Sclerosis & Sclerosis of Basilar Vessel with Rupture.
Hemorrhage at Base of Brain
(Sudden)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) F. C. Smith, M. D.
Oct 17 th (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bet Olam Cem	10-19-29
20 UNDERTAKER	ADDRESS
Hunt Undtkg Co	916 W.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

9 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 50225 ✓ E 50225

HEALTH DEPARTMENT—CITY OF BALTIMORE E 50225

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 12-51 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Jones

(a) RESIDENCE NO. 2931 Bernard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ?yrs. 2mos. 2ds. How long in U. S., if foreign birth? -yrs. -mos. -ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Amos Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mollie A. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed OCT 9 1929 C. HAMPSON JONES, M. D. Registrar

By ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1929 to Oct. 17, 1929

that I last saw him alive on Oct. 17, 1929

and that death occurred, on the date stated above, at 1:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Fascia

(duration) over 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis, chronic Arteriosclerosis

(duration) over 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P. E. Lab

(Signed) Marvin M. McLean, M. D.

10-17, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Mercer Gen	10-17 1929
19 UNDERTAKER	ADDRESS
Daniel Easton	916 Pa

Spec.—1-10-21—M&T—1500 Blks.

Paul. Raspi

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 50226

E 50226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. (St.) 26-37 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Raspe

(a) RESIDENCE NO. 3420 Gough ST. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs ... mos ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) January 31, 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		F	18	16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Raspia

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Pasquarella

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14

Informant Louis Raspia

(Address) 3420 Gough St

15

Filed OCT 19 1929 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/17 1929

17

I HEREBY CERTIFY, That I attended deceased from 10/17/29, to 10/17, 1929.

that I last saw h alive on 10/17, 1929.

and that death occurred, on the date stated above, at 6:20 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Pneumonia

(duration) yrs. mos 3-7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Clinical

(Signed) A. F. Gilmer, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Oct 19 29

UNDERTAKER: Kendall J. Lippert — ADDRESS: 311 E. Biddle

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 50227

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1509 Henry ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John McClellan Scott

(a) RESIDENCE NO. 1509 Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie Scott

6 DATE OF BIRTH (month, day, and year) Feb. 21 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer B.& O. Railroad 0/3

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER John W. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary J. Deavers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Sadie Scott (Wife)

(Address) 1509 Henry St.

Filed 10 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from 3.18.26, 19, to 10.17.29, 19, that I last saw h im alive on 10.17.29, 19 and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical-Clinical-Microscopic

(Signed) Philip B. Fowler M. D.

10.19.29 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Oct 21 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50228

CERTIFICATE OF DEATH

129 E 50228

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 256 No. London Ave St. 20-71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Asa Taylor

(a) RESIDENCE NO. 256 No London Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. ✓ mos. ds. How long in U. S. if of foreign birth?— yrs. ✓ mos ✓ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Jennie E. Taylor.

6 DATE OF BIRTH (month, day, and year): Sept. 14 - 1852

7 AGE — Years: 77 — Months: 6. — Days: 1 — IF LESS than 1 day ___ hrs. or ___ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired (Salvage Corps)

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town): Richmond

(State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Mary Jane Moody

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Richmond Va.

14 Informant: Mrs Jennie Taylor

(Address): 256 London Ave

15 Filed ___, 19___ Registrar

OCT 19 1929 C. HAMPSON JONES, M. D.

Del

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Oct. 18, 1929, that I last saw him alive on Oct 17, 1929, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 7 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary): Nephritis Chronic

(duration) 5 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted

If not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) Geo. C. Hamson M. D.

10/18, 1929 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — Date of Burial: Oct 21 1929

20 UNDERTAKER: Wm Tuckner Sons — ADDRESS: N Y Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—A&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50229

CERTIFICATE OF DEATH.

24 E 50229

1-PLACE OF DEATH

CITY OF BALTIMORE—(No.) Mitchell West Baltimore General Hospital ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Henry Cann

(a) RESIDENCE NO. 714 N. Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Cann

6 DATE OF BIRTH (month, day, and year): Sept 23 1860

7 AGE: Years 69 Months 0 Days 23 If LESS than 1 day, hrs. or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Druggists

(c) Name of employer: Henry Lehnert Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Michael Cann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Carrie Gaby

(Address): 714 N. Fulton Ave

15 Filed OCT 19 1929 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7th, 1929, to Oct. 18, 1929, that I last saw h[illegible] alive on Oct. 18, 1929 and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

c Hemiplegia (duration) yrs mos 16 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs mos ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. K. Castagna, M. D.

, 19 (Address) W. Balto. Jan 1 1930.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: Oct 22 1929

20 UNDERTAKER: J. Pius Kramer & Son

ADDRESS: Baltimore

PRESS IS VERY important—See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Blks.

E 50230

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50230

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 E. Biddle ST., 8-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grafton Halstead

(a) RESIDENCE NO. 1602 E. Biddle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced RUSBAND of (or) WIFE of Julia Halstead

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer M & M. S.S. Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edwin Halstead

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Sarah Amelia Cline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14

Informant Mrs. Gould

(Address) 612 E. Biddle St.

15

Filed OCT 19 1929, 19 H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1929

17

I HEREBY CERTIFY, That I attended deceased from July 6th, 19 29, to Oct 18th, 19 29

that I last saw him alive on Oct 18th, 19 29

and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis
& Dilatation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

10 (Signed) Howard Holbrook M. D.

19 . 19 29 (Address) 1711 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Oct. 21 1929
20 UNDERTAKER Wm. Pickerdon	ADDRESS North Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50231

CERTIFICATE OF DEATH.

74-001 E 50231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5415 Mayview Av ST. 26-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Carrie M. Bozman,

(a) RESIDENCE No. 5415 Mayview Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	W -

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1867 -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Henry Pusey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Raymond N. Bozman

(Address) 1801 N. Milton Av.

15 Filed OCT 20 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from May, 1926, to Oct. 19, 1929, that I last saw her alive on Oct. 19, 1929, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Arterio - Sclerosis & hypertension. (Cerebral apoplexy)?

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lowell Pengley, M. D.

10/29, 1929. (Address) 1000 E. Balt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairfield Cemetery - Salisbury - Md	Oct. 20 1929.
20 UNDERTAKER	ADDRESS
Charles J. Schwab.	505 N. Monroe St.

FROM IN very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50232

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 90

CITY OF BALTIMORE: (No. ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hugh Gallagher

(a) RESIDENCE NO. 207 Albermarle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0 K O

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER John Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Farley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 2 8 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 18, 19 29 to Oct. 17, 19 29

that I last saw him alive on Oct. 17, 19 29

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Focal

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. Of C

(Signed) Marvin M. McLean, M. D.

10/9, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	10/20 19 29
20 UNDERTAKER David Easton	ADDRESS 916 Pasan

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50233

CERTIFICATE OF DEATH

94-001 E 50233

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3202 Clarmer ave ST. 8-45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Glantz

(a) RESIDENCE NO. 3202 Clarmer ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. da. How long in U. S., if foreign birth ~~here~~ yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Henry Glantz

6 DATE OF BIRTH (month, day, and year) April 1 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	81	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gustav Kracht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis L. Glantz

(Address) 3202 Clarmer Ave

15 Oct 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 - 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb 18, 1929, to Oct 19, 1929.

that I last saw h[er] alive on Oct 16, 1929

and that death occurred, on the date stated above, at 11:15 A. m.

The CAUSE OF DEATH* was as follows: Uterine - Sclerosis

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 9 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Kent, M. D.

10/19, 1929 (Address) 413 N. Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gate Lawn Cemetery — DATE OF BURIAL Oct 22 1929

20 UNDERTAKER Henry Lutz — ADDRESS 1203 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

E 50234

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50234

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2553 Madison Ave St. 13-59 Ward)

2-FULL NAME Blanche Kelly

(a) RESIDENCE NO. 2553 Madison Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 06

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Lucius Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sadie Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Albert Kelly Bro.

(Address) 2553 Madison Ave

15 Filed Oct 20 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 25, 1929, to Oct 18, 1929,

that I last saw her alive on Oct 18, 1929,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis & Complete Anuria (duration) yrs. 3 Wks. ds.

CONTRIBUTORY (Secondary) Hypertension, & Facial Paralysis (duration) yrs. 3 wks. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. F. Young, M. D.

Oct 19 1929 (Address) 172 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: White Stone Lancaster Co. Va — DATE OF BURIAL: Oct 22 1929

20 UNDERTAKER: Mrs Chas G. Bailey — ADDRESS: 172 Jefferson St

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 50235

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1909 W. North Ave. (Ward) 15-21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura V. Cashmyer

(a) RESIDENCE NO. 1909 W. North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Cashmyer

6 DATE OF BIRTH (month, day, and year): Jan 1863

7 AGE: Years 66 | Months 9 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jos. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Eliza La Fauce

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Chas W. Bayne

(Address) 119 E. Fort Ave

15 Filed: OCT 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 18-1929

17 I HEREBY CERTIFY, That I attended deceased (from) Aug. 29 1929 to Oct. 18 1929 that I last saw her alive on Oct. 17. 1929 and that death occurred, on the date stated above, at 3 1/4 p m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) Years yrs. mos. ds.

CONTRIBUTORY (Secondary): Hard Kidneys

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Fauce M. D.

(Address) 1215 Fauce Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: Oct 21 1929

20 UNDERTAKER: Harry W. Eblen — ADDRESS: 1944 W. North Ave

Spec.—2-29-28—L. P. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50236

CERTIFICATE OF DEATH

88 E 50236

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2011 Portugal St. ST., 2-4 WARD)

2—FULL NAME Teresa Socha

(a) RESIDENCE NO. 2011 Portugal St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk. 1904.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Vesil Socha

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Dragan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Vesil Socha
(Address) 2011 Portugal St

15 OCT 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1929

17 I HEREBY CERTIFY, That I attended deceased from 1923, 19..., to Oct 18, 1929
that I last saw h.. alive on Oct 8, 1929
and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Cancer

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocard. Lt.

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs

(Signed) Geo. W. Lee, M. D.

Oct 20 1929 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Oct	21. 1929

20 UNDERTAKER W. Ozarowski ADDRESS 1938 Eastern Av

Spec.—8-16-29—L. F. S.—100 Bks.

E 50237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 0? 50237

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 903 E. Biddle ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Trecariche

(a) RESIDENCE NO. 903 E. Biddle ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if foreign birth? 30 yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Calgero Trecariche

6 DATE OF BIRTH (month, day, and year) ? 1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 037

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Pardo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Tuttarro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Husband, - Calgero Trecariche

(Address) 903 E. Biddle St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar.

2 0 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Oct 18, 1929, that I last saw her alive on Oct 17, 1929 and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ... yrs. ... mos. 6 da.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? ?

(Signed) Eugene L. Pearson M. D.

10.18.1929 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 21 1929
20 UNDERTAKER Pearson & Rio	ADDRESS E Balto St

Spec.—2-29-28—L. F. S.—500 Blks.

E 50238

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50238

CERTIFICATE OF DEATH

100-09

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 904 N. Eilmor St. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa Bell Flowers

(a) RESIDENCE NO. 904 Eilmor ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Cr	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/26/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	252	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Richard F Cowers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Eliz Boston

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Father
(Address) 904 Eilmor St.

Filed 2 0 1929, 19 H. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/29

17 I HEREBY CERTIFY, That I attended deceased from 10/8/29, 19..., to 10/19/29, 19...

that I last saw h.. alive on 10/19/29, 19...

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
(Primary)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Hurst, M. D.

10/19, 19 29 (Address) 912 Eilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-21 1929
20 UNDERTAKER David Carter	ADDRESS 916 Pa ave.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50239

CERTIFICATE OF DEATH

3 | E 50239

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2207 Ething ST. 11-59 WARD)

2—FULL NAME Mary Jane Warren

(a) RESIDENCE NO. 2207 Ething ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 11 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Warren

6 DATE OF BIRTH (month, day, and year) Nov 7, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer Public

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Wesley Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa

12 MAIDEN NAME OF MOTHER Alice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa.

14 Informant Thomas Warren Jr

(Address) 2207 Ething St

15 Filed 2 0 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 19 29, to Oct 17, 19 29, that I last saw h. ex alive on Oct 16, 19 29 and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

" Phthisis

(duration) 1 + yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. A. Wright M. D.

10/18, 19 29 (Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon	Oct. 20, 1929
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1125 Eastland Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50240

CERTIFICATE OF DEATH

124 E 50240

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Leah Fritsch

(a) RESIDENCE NO. 1919 E. Balto. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Ambrose A Fritsch

6 DATE OF BIRTH (month, day, and year) Jan 24 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	47	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) (General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Scott Vain

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Loheta Starkey

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Hospital Records
(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D.
Registrar

OCT 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/29

17 I HEREBY CERTIFY, That I attended deceased from 10/14, 1929, to 10/19, 1929, that I last saw h. alive on 10/19, 1929 and that death occurred, on the date stated above, at 7 05 A m.

The CAUSE OF DEATH* was as follows:

Cholecystitis with Stone in commonduct

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/16/29 Removal of Gall Bladder

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Wm N. McFaul Jr, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Oct 23 1929

20 UNDERTAKER Mr. W. E. Dufaldine

ADDRESS 37 Lawn

Cor.—10-10-29—A Co.—100 Blks.

E 50241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50241

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 26-37 Ward)

2-FULL NAME Caroline Reis

(a) RESIDENCE NO. Stemmers Run Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis C. Reis

6 DATE OF BIRTH (month, day, and year) Feb. 9, 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62	8	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) at Home 03
(c) Name of employer

9 BIRTHPLACE (city or town) York Pa
(State or country)

PARENTS

10 NAME OF FATHER John G. Beh

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Annie Myer

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Thos. Reis
(Address) Stemmers Run

15 Filed ....., 19.... HARRISON JONES, M. D. Registrar

OCT 20 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was an autopsy? — What confirmed diagnosis? —

(Signed) Geo. C. Heiss, M. D.

, 19 (Address) 143 E. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	Oct 21 1929
20 UNDERTAKER John A. Moran	ADDRESS 3000 E. Balto St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Mary E. Kay

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50242

CERTIFICATE OF DEATH

90 E 50242

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST., 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Kay

(a) RESIDENCE NO. Preston & Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md

PARENTS

10 NAME OF FATHER William Bolt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Moffitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Caroline Sts

15 Filed ..., 19 Registrar

20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19/29

17

I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 19, 1929, that I last saw her alive on Oct 19, 1929, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr I Bernstein M. D.

Oct 20, 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Oct 21 1929
20 UNDERTAKER	ADDRESS
H S Marshall	3539 Fall Rd

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50243

CERTIFICATE OF DEATH

E 50243

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Kleeger.

(a) RESIDENCE NO. 82-44 167th St. Jamaica L.I. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20	----;	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Jockey.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Kleeger.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Sarah Grodinsky.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia.

14 Informant Herman Kleeger. (brother)
(Address) 2145 E. 1st St. Brooklyn N.Y.

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 18, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the ribs and puncture of the lung. Occidental fall from a horse during a race.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Laurel Md. 10/18/29

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

10/19, 1929 (Address) 1007 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	10/20 1929
20 UNDERTAKER	ADDRESS
J. F. Schaaf & Sons	3116 Eutaw Pl.

OCT 20 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

Dr Hemming Page over to follow

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50244

CERTIFICATE OF DEATH

5 2 ✓ E 50244

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2536 McHenry ST. 20-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer R Kelch

(a) RESIDENCE NO. 2536 McHenry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 28. 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER August Kelch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmine Rodlin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant August Kelch
(Address) 2536 McHenry St

15 Filed 2 1 1929, 19 C. HAMPSON JONES, Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17. 1929

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to Oct 17, 1929, that I last saw him alive on Oct 17, 1929 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Secondary anaemia

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H Heller Hemming M. D.

10/19 1929 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mistern	10/21 1929
20 UNDERTAKER W. M. Cook	ADDRESS 1217 E Fay

Spec.—8-16-29—L. F. S.—100 Bks.

E 50246 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 740 E 50245

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. Aug 6-37

CITY OF BALTIMORE (No. 6702 Bessemer Ave ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret E Wiseman

(a) RESIDENCE NO. 6702 Bessemer Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Wiseman

6 DATE OF BIRTH (month, day, and year) Nov 15, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	5 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo Wiseman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mattie Thomason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William Wiseman

(Address) 6702 Bessemer Ave

15 Filed OCT 21 1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 20, 1929, that I last saw h[illegible] alive on Oct 19, 1929, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. W. Reiss, M. D.

10 22 1929 (Address) 2 Windsor Rd. Irvindale Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 10 23. 1929

UNDERTAKER W. Cook

ADDRESS 127 St Paul St

Spec.—1-12-23—M&T—500 Blks.

E 50246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 50246

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 262 Robert St. ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stillborn Daughter Lee

(a) RESIDENCE NO. 262 Robert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Elizabeth Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Virginia Lee (Address) 262 Robert St.

15 Filed 2 1 1929 C. HAMPSON JONES, M. D. Registrar

By E K G

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1929, to Oct 20, 1929.

that I last saw her alive on Oct 20 1929

and that death occurred, on the date stated above, at 5-P m

The CAUSE OF DEATH* was as follows: Premature Birth (Congenital Syphilis) Uterine Gestation Int. of

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) R. Garland Chandlee, M. D.

(Address) 1534 Druid Hill Ave. Oct. 20, 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-21 1929

20 UNDERTAKER George T. A. Gibson ADDRESS 1736 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50247

CERTIFICATE OF DEATH

1871-89 E 50247

1-PLACE OF DEATH

City of Baltimore: (No. 339 W. Fayette St. 20-69 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Boblit

(a) RESIDENCE NO. 2512 Frederick Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Boblit

6 DATE OF BIRTH (month, day, and year) Feb. 20 - 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	54	7	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Towson & Groce Co.

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Charles Boblit

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Barber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Laura Boblit
(Address) 2512 Frederick Ave

Filed OCT 21 1929 G. HAMPSON JONES, M. D., Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushing wound of Chest Caused by 1500# Press falling on him Accidental Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

10-19-1929 (Address) 733 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	Oct. 21-1929.

20 UNDERTAKER Charles J. Schwab. ADDRESS 505 N. Monroe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 ✓ E 50248

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. (Institution) Infirmary ST. 4-25 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Grace Moore.

(a) RESIDENCE NO. 5 W. Franklin St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred About 30 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) ------ 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
61 yrs.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) ... do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Centerville Maryland

PARENTS

10 NAME OF FATHER John T. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queen Anne Maryland

12 MAIDEN NAME OF MOTHER Sallie Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Maryland

14

Informant John T. Moore
(Address) 837 Hamilton Terrace

Filed OCT 21 1929, 19 C. HAROLD JONES, M. D. Registrar

Via Balto. & Virginia Steamboat Co. Escort - John T. Moore

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1929

17

I HEREBY CERTIFY, That I attended deceased from May 4, 19 29, to Oct 20, 19 29,

that I last saw h Oct 20/29, 19 29

and that death occurred, on the date stated above, at 3:45 A m.

The CAUSE OF DEATH* was as follows:

Cause of the Coroner.

(duration) X yrs. 7 mos X ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of May 4 29

Was there an autopsy? No.

What test confirmed diagnosis? Pathological Histological

(Signed) Chas B Wallace, M. D.

, 19 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Centerville, Md.	10/21 19 29
20 UNDERTAKER Henry W. Mars and Son	ADDRESS 703 N. Calvert

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 50249

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 20 S. Chester St 2-4 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Myer Auslander

(a) RESIDENCE NO. (Usual place of abode) 20 So. Chester ST., WARD

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? 27 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ethel Auslander

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Auslander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ethel Auslander

(Address) 20 S. Chester St

15 Filed OCT 21 1929, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to date 14, 1929, that I last saw him alive on Octo 14, 1929, and that death occurred, on the date stated above, at 2.15 P. M.

THE CAUSE OF DEATH* was as follows: Carcinoma of Rectum Metastasis to Lungs

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Myocarditis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Physical Examination

What test confirmed diagnosis?

(Signed) Saml Kopelowitz M. D.

. 19 (Address) 1627 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Cemetery — DATE OF BURIAL 10/21 19 29

20 UNDERTAKER Jack Lewis — ADDRESS 1639 E Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

48 ✓

E 50250

CERTIFICATE OF DEATH

REGISTERED NO. E 50250

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3042 (STREET) Remington Ave 4-3-51 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George F. Kirby

(a) RESIDENCE NO. 3042 Remington Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ella B. Kirby

6 DATE OF BIRTH (month, day, and year): Jan. 9-1860

7 AGE: Years 69 | Months 9 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Letter Carrier 30 0
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 4 years
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbott Co. Md

PARENTS

10 NAME OF FATHER: William R. Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mahala Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Charles C. Kilmon
(Address) 3042 Remington Ave.

15 Filed OCT 21 1929 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Oct 20, 1929, that I last saw h live on Oct 19, 1929, and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ear and Larynx

(duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Radium Treatment

What test confirmed diagnosis?

(Signed) Wade Hoff, M. D.

10/21, 1929 (Address) 2020 N. Charles.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Michaels Md — DATE OF BURIAL: Oct. 22 1929

20 UNDERTAKER: Grace H. Burgee — ADDRESS: 3031 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50251 — 129 ✓ — E 50251

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 W Lexington ST. 18-16 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Bartholomaeus

(a) RESIDENCE NO. 842 W Lexington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bartholomaeus

6 DATE OF BIRTH (month, day, and year) Aug 9-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	78	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Bartholomaeus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Springer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adam Bartholomaeus

(Address) 2803 Harlem ave

15 Filed 21 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18-1929

17 I HEREBY CERTIFY, That I attended deceased from January 7 1929 to October 18 1929 that I last saw h[illegible] alive on October 18 1929 and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

about 6 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular heart disease & interstitial nephritis (duration) Over 9 months yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Hist.

(Signed) Amy Cohen M. D.

10-19, 1929 (Address) 1203 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	10-21 1929
UNDERTAKER	ADDRESS
Mrs Chas A J Rohde	2327 Edmondson Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50252

CERTIFICATE OF DEATH

NH-9-01 E 50252

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 6019 Holabird Ave WARD 6-36)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Frances Selig

(a) RESIDENCE NO. 6019 Holabird Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Selig

6 DATE OF BIRTH (month, day, and year) 3/2/1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Carl Gladdung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Riedel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Nellie White Ford

(Address) 2802 Parkwood Terrace

15 2 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19-1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Oct 19, 1929, that I last saw her alive on Oct 19, 1929 and that death occurred, on the date stated above, at 10:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

10/30/29 (Address) 800 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Oct 22, 29

UNDERTAKER John Merrick

ADDRESS 2008 Arlington

Spec.—8-16-29—L. F. S.—100 Bks.

E 50253 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 50253

CERTIFICATE OF DEATH 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3122 E Lombard ST. 1-V WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Hall

(a) RESIDENCE NO. 3122 E Lombard ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Hall

6 DATE OF BIRTH (month, day, and year): Oct 15 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in whirh employed (or employer): ditto

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Fritz Knoche

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank Knoche

(Address) 3122 E Lombard

15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20-1929

17 I HEREBY CERTIFY That I attended deceased from Oct. 30, 1928, to Oct 20, 1929, that I last saw h er alive on Oct. 19, 1929 and that death occurred, on the date stated above, at 5-4 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Interstitial)

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel A Wolfe, M. D.

10/20, 19 (Address) 1331 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: Oct 23 1929

20 UNDERTAKER: John Ulrich — ADDRESS: 2108 Eutaw

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50254

CERTIFICATE OF DEATH.

90 E 50254

1-PLACE OF DEATH Declared at Hopkins REGISTERED NO.

City of BALTIMORE: (No. Fayette & Eden St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kent Wright

(a) RESIDENCE NO. 1230 Jefferson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years: about 45 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Caulker

(b) General nature of industry, business, or establishment in which employed (or employer) Globe Ship Dry.

(c) Name of employer

9 BIRTHPLACE (city or town) Roanoke Roanoke

(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mary Simon

(Address) 506 Hagerty Ave

15 Filed 19 NAMAN JONES, M. D.

By: Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Oct 13/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Dock (duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Wilson M. D.

(Coroner)

19 (Address) 10/21/29 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Oct. 29 27

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1725 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50255

CERTIFICATE OF DEATH

73 ✓

E 50255

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 743 Bradley St. 17-N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Wyman

(a) RESIDENCE NO. 743 Bradley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Wyman

6 DATE OF BIRTH (month, day, and year) Feb 19-1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	55	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Landress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) A A Co Md
(State or country)

PARENTS

10 NAME OF FATHER John Goodin

11 BIRTHPLACE OF FATHER (city or town) A A Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Rodie Jolly

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant John Goodin
(Address) 520 Robert St

15 Filed 2 1 1929, 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (Month, day and year) Oct 19th 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Ascending Paralysis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Hicks M. D.

(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	10/21/1929
20 UNDERTAKER	ADDRESS
Mrs. Ks. H. Holland	163 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 188-203 ✓ E 50256

1-PLACE OF DEATH

City of Baltimore: (No. St Agnes Hosp St. 75-72 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul F. Newton

(a) RESIDENCE NO. Mint Franklin Ward Lansdowne Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 21 — 1915

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	14	3	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Fredk Newton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Lula Hutchinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Lula ~~Hutchinson~~ Newton
(Address) Mint and Lane

15 Filed OCT 1 1929, 19...

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Multiple fractures including fracture skull by being run into side of heavy automobile
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3rd & Wash Ave Lansdowne
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis Clinical

10/21, 1929 (Signed) H J Frame M. D.
(Address) 1939 W Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Oct 23, 1929
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Lombard

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 50257

CERTIFICATE OF DEATH.

90 E 50257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Rosekemp Ave ST., 47-44 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melanie Hellmuth Hellmuth

(a) RESIDENCE No. 3501 Rosekemp Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hellmuth

6 DATE OF BIRTH (month, day, and year) July 8th 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 07

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Alsace Braine Germany

PARENTS

10 NAME OF FATHER Jacob Krob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown 04/6

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Hellmuth
(Address) 3501 Rosekemp Ave.

15 Filed OCT 21 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 19 29 to Oct 18, 19 29.

That I last saw h alive on Oct. 18, 19 29, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis
Endocarditis (duration) Chronic yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Clara Jones, M. D.

19 29 (Address) 4 7 8 B Hamps Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	Oct 21 1929
20 UNDERTAKER Frederick Lasahn & Sons	ADDRESS Fullerton

THIS is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50258

V 18-103
18 E 50258

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Provident Hospital St., 12-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Johnson

(a) RESIDENCE NO. 1213 Argyle Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 5 - 1921

7 AGE: Years 8 Months 4 Days 12 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Edward Gran

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Wharton

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Mary Wharton

Address: 1213 Argyle Ave

T 2 1 1929

15 Filed....., 19..... C. HAMILTON JONES, M. D.

Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull

Knocked down by motor auto

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Traumatic Shock

(Duration) yrs. mos. ds.

(Signed) C. Hamilton Jones M. D.

(Coroner)

10/21, 1929 (Address) 2939 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 1100 block Argyle ave

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Date of Burial Oct 21 1929

20 UNDERTAKER: Samuel T. Hemsley ADDRESS 1711 Bolton

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 50259 HEALTH DEPARTMENT—CITY OF BALTIMORE 42 50259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 Annabel St. 25-75 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Arnold

(a) RESIDENCE No. 408 Annabel Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emmanie P. Arnold

6 DATE OF BIRTH (month, day, and year): May 18th 1864

7 AGE: Years 65 Months 5 Days 1

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Asst Foreman 073

(b) General nature of industry, business, or establishment in which employed (or employer): B & O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A.R.Co. Ind.

PARENTS

10 NAME OF FATHER: Samuel Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): A.R.Co. Ind.

12 MAIDEN NAME OF MOTHER: Camelia Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A.R.Co. Ind.

14 Informant (Address): Mrs. Emmanie P. Arnold 408 Annabel Ave

15 Filed 1929 E. HAMPSON JONES, M. D. Registrar

JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 9th, 1929, to Oct 19th, 1929, that I last saw him alive on Oct 18th, 1929, and that death occurred, on the date stated above, at 6 05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver

(duration) — yrs 1 mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination.

(Signed) Roy Heibel M. D.

Oct. 1929 (Address) 1724-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Oct. 22 1929

20 UNDERTAKER: George L. Schmidt — ADDRESS: 2101 Eutaw Ave

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION may be property classified. Exact statement of OCCUPATION may be necessary. TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50260

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 50260

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 20-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ella Lentzer

(a) RESIDENCE No. 1906 Lemon ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Lentzer

6 DATE OF BIRTH (month, day, and year) May 9-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	48	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Benjamin Storney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Ella Lentzer

(Address) 1906 Lemon St. City

15 Filed 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 19 29

17

I HEREBY CERTIFY, That I attended deceased from Oct - 18, 19 29 to Oct 18, 19 29,

that I last saw h[illegible] alive on Oct 18, 19 29

and that death occurred, on the date stated above, at 3:15 P m

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery DATE OF BURIAL Oct 22 19 29

20 UNDERTAKER George L. Lehnhardt ADDRESS 3101 Eutaw Ave

ATTENTION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 50261

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital 26-27 St. ..... Ward)

REGISTERED NO. 191

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. Loughlin

(a) RESIDENCE NO. Edgewood Md St. ..... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) New Jersey N.J.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) unknown

14 Informant Thomas Quinn

(Address) Edgewood Md

15 Filed ..... 1929 C. HAMPSON JONES, M. D.

Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

THE CAUSE OF DEATH was as follows:

Homicide Gun Shot wound of Head,

(duration) ..... yrs. Instant mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. — ds.

Oct 20 1929 J C Slades M. D.

(Coroner)

.19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Abingdon Cemetery	Oct 23 1929
20 UNDERTAKER	**ADDRESS**
Howard K McComas	Abingdon

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50262

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 50262

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 122 S. Exeter St., 35 Ward)

REGISTERED NO. 188-10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Miller

(a) RESIDENCE NO. 122 S. Exeter St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Miller

6 DATE OF BIRTH (month, day, and year) May - 10 - 1866

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	62	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stock
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic 37
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Louis Lohaly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Lafotta

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Louis Miller
(Address) 122 S. Exeter St.

15 Filed OCT 21 1929 19

C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Hemorrhage of Cranium due to Contusion due struck & knocked down by auto Oct 12-29 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Low & Exeter Sts

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr. Clinical

(Signed) H. Brann M. D.

10/20/29 (Address) 2931 Mt. Elden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	10-22-29

20 UNDERTAKER Kendall & Hopper ADDRESS 1 E Eden

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50263

CERTIFICATE OF DEATH.

E 50263

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ST. 27-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meanade Saks

(a) RESIDENCE No. 2310 Rogers Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Saks

6 DATE OF BIRTH (month, day, and year) Nov 3, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carlisle, Pa.

PARENTS

10 NAME OF FATHER Sam'l Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ellen Kronwald

13 BIRTHPLACE OF MOTHER (city or town) Hanover (State or country) Pa.

14 Informant (Address) H. J. Saks 2310 Rogers Ave

15 Filed OCT 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16 1929 to Oct. 21 1929.

that I last saw her alive on Oct. 21 1929

and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Active T.B., bilateral Chronic Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, clinical

(Signed) Bernard Sobel M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	10-23 1929

20 UNDERTAKER Heard Sanderson ADDRESS 1110 Eutaw Pl.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 50264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 50264

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 602 Dumbarton St., 9047 Ward)

2-FULL NAME Nellie M Seltzer

(a) RESIDENCE NO. 602 Dumbarton St. 10E Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. A. Seltzer

6 DATE OF BIRTH (month, day, and year): April 27 1859

7 AGE: Years 50 | Months 5 | Days 4 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Pocomoke City
(State or country)

PARENTS

10 NAME OF FATHER: Chas J Henderson

11 BIRTHPLACE OF FATHER (city or town): Pocomoke City
(State or country)

12 MAIDEN NAME OF MOTHER: Elmira E. Clogg

13 BIRTHPLACE OF MOTHER (city or town): Pocomoke City
(State or country)

14 Informant: William G Seltzer
(Address) 602 Dumbarton Ave

Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar
Per .....

T 2 1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19-1929 19

17 I HEREBY CERTIFY, That I attended deceased from June 1 1929, to Oct 19 1929,
that I last saw h.... alive on Oct 18 1929,
and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:
Chr. Myocarditis. Chr. Bil. Nephritis
Ascites. Edema of thighs.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Same.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) S W Bishop, M. D.
Oct 19. 1929 (Address) 501 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial 10/22/29

20 UNDERTAKER: Chas P. Crane & Son ADDRESS 1118 N. Eutaw St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50265

CERTIFICATE OF DEATH

129 E 50265

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2520 Mc Elderry St. (If not in a hospital) WARD) 9th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas C Prentz

(a) RESIDENCE NO. 2520 Mc Elderry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE~~ of Anna M. Prentz

6 DATE OF BIRTH (month, day, and year) Aug 30-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry B Prentz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: E Humphreys

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Anna M Prentz

(Address) 2520 Mc. Elderry St

15 Filed 21 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 20, 1929, that I last saw him alive on Oct 20, 1929 and that death occurred, on the date stated above, at 5 00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) cardio-vascular-renal-arterial Hypertension (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine exam—

(Signed) Louis F Krumeich, M. D.

, 19 (Address) 722 N. Kenwood Ave-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct 23 1929
20 UNDERTAKER	ADDRESS
Chas E. Miller & Son	3594 Elm Ave

Spec.—1-12-23—M&T—500 Bks.

E 50266

HEALTH DEPARTMENT—CITY OF BALTIMORE

50266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Elmtree Street Curtis Bay ST. 25-27 WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Waytekunas

(a) RESIDENCE No. 1603 Elmtree Street Curtis Bay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. ds. How long in U. S., if of foreign birth? 27 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M.Kalinavskas

6 DATE OF BIRTH (month, day, and year) No 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No.

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Peter Waytekunas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anne Plungis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant M.Waytekunas (Address) 1603 Elmtree St.

15 Filed 2 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1929

17 I HEREBY CERTIFY, That I attended deceased from July 5 , 1929 , to Oct 19 , 1929 , that I last saw him alive on Oct 18 , 1929 , and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Anthony V. Buchheit , M. D.

10/30 , 1929 (Address) 37 E Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct. 23. 1929

20 UNDERTAKER ADDRESS

John Grebliauckas & Co. 423 S Paca St

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 50267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

197 E 50267

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hos. St., 18-2a Ward)

2-FULL NAME Jno. Loveday

(a) RESIDENCE NO. 1217 St. Fairmount Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) July 15, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	49	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Loveday

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West Indies

14 Informant Harry Loveday
(Address) 1217 St. Fairmount

15 Filed ..... 19.....

21 1929 C. W. SINGLETON [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.
The CAUSE OF DEATH* was as follows:
Internal Hemorrhage
Caused by gun shot
Homicide

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. W. Brooke, M. D.

Oct 21 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md. Altum Cemty	Oct 2 1929
20 UNDERTAKER	ADDRESS
Walter B Sprigg	134 N. Howard St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50268

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 50268

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St Josephs Hosp ST. 27-402 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Spahn

(a) RESIDENCE NO. 4007 Chesley Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper at Ato

(b) General nature of industry, business, or establishment in which employed (or employer) American Can Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Conrad G. Spahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mr. Conrad Spahn
(Address) 4007 Chesley Ave Balto

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

CT 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Oct 19, 1929, that I last saw him alive on Oct 19, 1929 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac Dilatation

(duration) yrs. mos. Sudden

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & Clinical

(Signed) M M Hackney M. D.

19 29 (Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 22 1929
20 UNDERTAKER	ADDRESS
Kinney Brock Sons, Inc	130 E Eager St

Spec.—1-12-23—MAT—500 Blks.

E 50269

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001 E 50269

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N High St 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Dorsey

(a) RESIDENCE No. 419 N. High St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

5a If married, widowed, or divorced (or) WIFE of Louis Dorsey

6 DATE OF BIRTH (month, day, and year) Dec 25 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9	25	
46		10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Franklin Veals

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Veals

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Louis Dorsey (Address) 419 N High St

15 Filed 2 1 1929

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20/29 19

17 I HEREBY CERTIFY, That I attended deceased from 10/18/29, 19 .. to 10/20/29, 19, that I last saw h[illegible] alive on 10/19/29, 19, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac ulcer Ruptured

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Reported was to Hospital Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Samuel J. Fay, M. D.

11/, 1929 (Address) 710 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL 10 of 23 19 29

20 UNDERTAKER Robert Wilkins ADDRESS 1515 M[illegible]

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50270

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2913 Montebello Terrace ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Brennan

(a) RESIDENCE NO. 2913 Montebello Terrace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 6 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Ella M. Brennan

6 DATE OF BIRTH (month, day, and year) Apr. 13' 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis F. Brennan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William F. Brennan Jr.

(Address) 2913 Montebello Terrace

15 Filed OCT 21 1929 C. H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1929, to Oct 20th 1929.

that I last saw him alive on Oct 20 1929

and that death occurred, on the date stated above, at 12:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) L. L. Gordy. M. D.

10-20 1929 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	October 23 1929
20 UNDERTAKER	ADDRESS
Harry Hoerle Sons Inc	1301 E Eager

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50271

CERTIFICATE OF DEATH

167-001 ✓ E 50271

1-PLACE OF DEATH

City of Baltimore: (No. 939 N. Calvert St. 11-15 Ward)

2-FULL NAME Mrs. A. Wilson ? (New Lady)

(a) RESIDENCE NO. 439 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married ??

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: about 30 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mrs. Hall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed OCT 21 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Riley Coroner M. D.

Oct 7, 1929 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY.

DATE OF BURIAL: 19 OCT 21 1929

20 UNDERTAKER: Commissioner Health.

ADDRESS

Per. Wm. E. Woods

Should be carefully supplied. All items should be stated EXACTLY. PHYSICIANS should be particular that entries be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50272

CERTIFICATE OF DEATH.

31 E 50272

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 729 S Bway St. 2-4 (Ward)

2-FULL NAME Stefan Wolarozyk

(a) RESIDENCE NO. 729 S Bway St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town).....

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town).....

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town).....

(State or country)

14

Informant .....

(Address)

15 Filed ..... 19 C. HAMPSON JONES, M. D.

By ..... Registrar

OCT 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour) Oct 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Pul TB

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) C. H. Jones, M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

PUBLIC CEMETERY

20 UNDERTAKER Commissioner Health. ADDRESS

OCT 21 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50273

CERTIFICATE OF DEATH

100-001

E 50273

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST., 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herman Zimmer

(a) RESIDENCE NO. 1102 Burgundy ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fried Ziemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Florence Hester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record
(Address)

15 Filed OCT 21 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20/29

17 I HEREBY CERTIFY, That I attended deceased from 7/15, 19 29, to 10/20, 19 29

that I last saw h.. alive on 10/20, 19 29

and that death occurred, on the date stated above, at 4:40 a.m.

The CAUSE OF DEATH* was as follows:

Senility - Arteriosclerosis -
Senile gangrene right foot -

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7/19/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Compton, M. D.

10/20, 1929 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL Oct 21 1929

20 UNDERTAKER Commissioner Health

ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50274

CERTIFICATE OF DEATH.

182 V E 50274

1-PLACE OF DEATH

City of BALTIMORE: (Ward, or Locality) Black Basin Fort Lauderdale St. 3 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(a) RESIDENCE NO. " St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: About 50 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ..... 19 ..... HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Drowning (Acc?)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

Oct 24/27 (Signed) A C Hales (Coroner) M. D.

19 (Address) 1730 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

Date of Burial 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

OCT 21 19

MFG. BY H. WOOLL,

23 OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 50275

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Church Home & Infirmary ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Becker

(a) RESIDENCE NO. 615 Hinan's Way, Hunting Ridge ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, Married, ~~Widowed~~ or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of August C. Becker

6 DATE OF BIRTH (month, day, and year) Dec 10th 1869

7 AGE Years 59 Months 10 Days 9 If LESS than 1 day, ... hrs. or ... min. 60

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Fredrick C. Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna. Schenk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs J. A. Ramsay

(Address) 615 Winans Way

15 Filed 2 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1929

17

I HEREBY CERTIFY, That I attended deceased from September 18 1929, to October 19, 1929, that I last saw he alive on October 19, 1929, and that death occurred, on the date stated above, at 11 = P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Enteritis

(duration) yrs. 12 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis Peritonitis; Cirrhosis Sclerosis; Myocardial failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H Norwood, M. D.

, 19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Oct. 22, 29.

20 UNDERTAKER Fredk A. Richardson — ADDRESS 703 E Hamilton Av

THION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 129 E 50276

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Washington

(a) RESIDENCE NO. Ellicott city Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Washington

6 DATE OF BIRTH (month, day and year) December 1892

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adams Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joshua Washington 45 E. (Address) Ellicott City Md

15 Filed 2 1 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1929, to Oct 20, 1929, that I last saw h alive on October 20, 1929 and that death occurred, on the date stated above, at 11:00 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.
Uremia - acute.

(duration) unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy findings.

(Signed) W. B. Johnston, M. D.

Oct. 23, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine Orchard Cem	Oct 23, 1929
20 UNDERTAKER Easton Sons	ADDRESS Ellicott City

Spec.—2-29-28—L. F. S.—500 Blks.

E 50277

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 50277

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME J. Wm. Smith

(a) RESIDENCE NO. 4002 Eastern Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jas. R. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Martha Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 2 1 1929, 19 C. HAMPSON JONES, M. D. at Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1929, to Oct. 20, 1929, that I last saw him alive on Oct. 20, 1929 and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic & acute

(duration) 5? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Hist & S

(Signed) Marvin M McKean, M. D.

10-21, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Delta Penna	Oct 22 1929
20 UNDERTAKER Henry Lutz Jr.	ADDRESS 1203 Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50278

CERTIFICATE OF DEATH

49 E 50278

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. South Baltimore General Hospital St., 12 Ward)

2-FULL NAME Bronislaus J.Ziomkowski. or John Lang.

(a) RESIDENCE NO. 3112 O'Donnell St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. da. How long in U. S., If of foreign birth 38 yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of Cecelia Ziomkowski.

6 DATE OF BIRTH (month, day, and year) June 20 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	66	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland.

PARENTS

10 NAME OF FATHER William Ziomkowski.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Cecelia Ziomkowski.(wife)
(Address) 3112 O'Donnell St.

15 Filed OCT 21 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Carcinoma of the Prostrate.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? 3112 O'Donnell St.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

10/21/29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Oct 23 1929
20 UNDERTAKER	ADDRESS
John M Weber	York & Chester Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 50279

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 3-4 Ward)

2-FULL NAME Andrew Andrychowski

(a) RESIDENCE NO. 830 S. Bond St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine Andrychowski

6 DATE OF BIRTH (month, day, and year) Oct 20 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	39	11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pants Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Lewis Andrychowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant San Andrychowski
(Address) 830 S. Bond St

15 [illegible] 1929 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc Fall down Steps
Fracture of Skull (duration) 4 hrs. mos.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) 4 hrs. yrs. mos.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 10/22, 29

20 UNDERTAKER F. W. Ozazewski 1930 Eastwood — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. & S.—100 Blks.

E 50280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 by Buchheit

L 50280

74-GL2468

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1819 St Charles ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna D. Dudley

(a) RESIDENCE NO. 1819 St Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John S. Dudley

6 DATE OF BIRTH (month, day, and year): Sept 29/58

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: William J Yopp

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Julia Warren

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

Informant: Mrs. James F. Strain

(Address): 1819 St Charles

Filed 2-1 1929, 19 HARPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20-29

17

I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Oct. 20, 1929,

that I last saw her alive on Oct. 20, 1929

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) Jean A. Buchheit, M. D.

, 19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilmington N.C.

DATE OF BURIAL: Oct 22 1929

20 UNDERTAKER: William Cook

ADDRESS: 121 St Paul St

Spec.—2-29-28—L. F. S.—600 Blks.

E 50281

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ E 50281

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto City Hosp ST., 9-18 WARD)

2—FULL NAME James Ray

(a) RESIDENCE NO. 1806 Aiken ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary land

PARENTS

10 NAME OF FATHER Andrew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary land

12 MAIDEN NAME OF MOTHER Sarah Crim

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary land

14 Informant Hospital Record
(Address)

15 Filed 2 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20/29

17 I HEREBY CERTIFY, That I attended deceased from 2/20, 1929, to 10/20, 1929

that I last saw him alive on 10/20, 1929

and that death occurred, on the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Senility. Generalized arteriosclerosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. [illegible] M. D.

10/21 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 23 1929

20 UNDERTAKER D. W. Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50282

CERTIFICATE OF DEATH

135 E 50282

1—PLACE OF DEATH 22 Druid Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & St., 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry M Andrews Sr

(a) RESIDENCE NO. 2215 Scott St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida L Andrews

6 DATE OF BIRTH (month, day, and year) Apr 6, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman, Clothing

(b) General nature of industry, business, or establishment in which employed (or employer) Supply

(c) Name of employer National Salvage Co

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Walter Blundyns

(Address) Ridgewood, Md

15 FEB 21 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-29

17 I HEREBY CERTIFY, That I attended deceased from 10-15-29, 19..., to 10-20-29, 19..., that I last saw him alive on 10-20-29, 19..., and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Prostatis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 10/22 19 29

20 UNDERTAKER [illegible] Cook — ADDRESS 1217 E Fayette St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 59283

CERTIFICATE OF DEATH

90 E 59283

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3026 W North Ave St. 15-67 Ward)

2-FULL NAME John H. Clabaugh

(a) RESIDENCE NO. 3026 W. North Ave., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	55	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm F. Clabaugh

11 BIRTHPLACE OF FATHER (city or town) Carroll Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Eliza A Geraghty

13 BIRTHPLACE OF MOTHER (city or town) Phila
(State or country) Penn

14 Informant Chas E. Clabaugh
(Address) 3026 W. North Ave

15 Filed ..... 19 HAMPSON JONES, Registrar
2 1 1929 By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Harold Hoblitzell M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	10/23 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks. Catherine Ehman

E 50284

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

V 001
143 E 50284

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 2748 Ward)

2-FULL NAME Catherine Ehman

(a) RESIDENCE NO. 509 Tunbridge Road St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter J. Ehman

6 DATE OF BIRTH (month, day, and year) Apr 23/1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none 27
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles F. Knox

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Belle McCauley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Walter J. Knox
(Address) 503 Oakland Ave

15 Filed ..... 19.... HAMPSON JONES Registrar

OCT 21 1929

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-Incomplete abortion.
(Accidental)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. S. Patton, M. D.

10-21-29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forkwood Cemetery	Oct 22, 29
20 UNDERTAKER	ADDRESS
Williams Cook	1217 Druid

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

23-50299 50285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 101-001 E 50285

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Russell Schneemeyer

(a) RESIDENCE NO. Whitehall Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	6			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nebraska
(State or country)

PARENTS

10 NAME OF FATHER Martin Schneemeyer dead

11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jurss aged

13 BIRTHPLACE OF MOTHER (city or town) Austria
(State or country)

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 22 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Oct 21, 1929, that I last saw h. alive on Oct 21, 1929 and that death occurred, on the date stated above, at 5.25 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (L.R.L.)

Acute Bacterial endocarditis

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) J. W. Bickford Jr. M. D.

19 (Address) J.H.H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill	Oct 23, 29
20 UNDERTAKER J. Fay Burns Sons	ADDRESS Towson

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50286

CERTIFICATE OF DEATH

1-001

E 50286

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital 14-20 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Winford Williams

(a) RESIDENCE NO. 525 Prestman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 20, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Austin Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rosa Wiggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant Austin Williams

(Address) 525 Prestman St

Filed OCT 22 1929 C. H. JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 29, 1929, to Oct 21, 1929,

that I last saw him alive on Oct 21, 1929

and that death occurred, on the date stated above, at 3.20 9 m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(B. Typhosus)

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical & Laboratory Report

(Signed) Myron G Tull, M. D.

10/21, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge, Md.	10/22/1929
UNDERTAKER	ADDRESS
Geo. H. Holland	163 Druid Hill

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50287

CERTIFICATE OF DEATH

181 E 50287

1-PLACE OF DEATH

City of Baltimore: (No. 4736 Park Heights Ave. 21-45 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances X. Sharretts.

(a) RESIDENCE NO. 4736 Park Heights Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward J Sharretts

6 DATE OF BIRTH (month, day, and year) Nov 8 1870

7 AGE	Years	Months	Days 12	IF LESS than 1 day ..... hrs. or ..... min.
	58	11	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER Thomas Newton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Frances Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wales

14 Informant Nellie G Sharretts
(Address) 4936 Park Heights

15 Filed ..... 19.. C. HAMPSON JAMES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Pneumonia Lobar

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct. 19 29 (Address) 3632 Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 22 1929
20 UNDERTAKER	ADDRESS
John O Mitchell Son	1400 Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 50288

E 50288

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME (Mrs.) Sadie Spencer

(a) RESIDENCE NO. 2510 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. (C.T.) mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Christian Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Andrew L. Spencer

(Address) 2319 N. Charles St.

Filed OCT 22 1929 HAMPSON JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to Oct 20, 1929, that I last saw her alive on Oct 20, 1929 and that death occurred, on the date stated above, at 2:45 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction (Fecal impaction of large intestine)

(duration) 0 yrs. 0 mos. 20 ds.

CONTRIBUTORY (Secondary) Terminal (Bronchial) Pneumonia

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? 2510 Maryland Ave. Balt. Md.

Did an operation precede death? Yes Date of Oct. 9. 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation & History

(Signed) Jesse I. Tyler, M. D.

10/22, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy.	Oct. 22 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell Sons	1900 Eutaw St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50289 89 ✓E 50289

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2534 W. Lanvale St. ST., 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie E. Beidelman

(a) RESIDENCE NO. 2534 W. Lanvale St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Beidelman

6 DATE OF BIRTH (month, day, and year) Apr. 25, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Camp Hill Pa.

PARENTS

10 NAME OF FATHER David Musser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Susie Coble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant John D. Beidelman
(Address) 2534 W. Lanvale St.

15 Date received OCT 22 1929 CLAMPOON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20 1929.

17 I HEREBY CERTIFY, That I attended deceased from October 4, 1929, to October 20, 1929.

that I last saw h[illegible] alive on October 20, 1929

and that death occurred, on the date stated above, at 2:55 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms

(Signed) Chester Piland, M. D.

10-4-1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Interring Camp Hill, Penna.	Oct. 22, 1929
20 UNDERTAKER John O. Mitchell & Sons	ADDRESS 1900 Eutaw Pl.

John O. Mitchell

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50290

CERTIFICATE OF DEATH

E 50290

1—PLACE OF DEATH

REGISTERED NO. 2299

CITY OF BALTIMORE: (No. Franklin Square Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Elizabeth Rollins

(a) RESIDENCE NO. 843 Montrose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	71	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Caphlins Wilt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs Mary Watkins

(Address) 2778 Pinkney Ave

15 Filed OCT 22 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929 to Oct. 21 1929

that I last saw h alive on Oct. 21 1929

and that death occurred, on the date stated above, at 2:5 a.m.

The CAUSE OF DEATH* was as follows:

Advanced Heart Failure

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James H. Phillips M. D.

(Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 23 1929
20 UNDERTAKER Jos Jacobs Son	ADDRESS 2178 B...

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50291

CERTIFICATE OF DEATH

E 50291

1-PLACE OF DEATH

City of Baltimore: (No. 42 E.York St. St., 22-6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J.Frank Loane.

(a) RESIDENCE NO. 42 E.York St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 0 ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced.

5a If [redacted] divorced HUSBAND of [redacted] Louise Loane.

6 DATE OF BIRTH (month, day, and year) December 19,1856

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	72	10	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Loane

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Elizabeth Morrison.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md

14 Informant Marie Smeitzer.(daughter)
(Address) 4808 Gwynn Oak Ave.

15 Filed OCT 22 1929 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 19,1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test (confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt M. D.

(Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 10/22 1929

20 UNDERTAKER William Cook ADDRESS 1617 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 199 ✓ E 50292

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., ~~24~~ 24-33 Ward)

2-FULL NAME Daniel K. O'Neill.

(a) RESIDENCE NO. Columbus, Georgia. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	40	---------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

Filed OCT 22 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquest (Inquest, autopsy or inquiry) find that said deceased came this death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the brain due to a fracture of the skull. Struck by a fist and knocked down. Homicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? S. A. O. R. R. Yards Locust Point. Oct. 20, 1929

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquest.

(Signed) Otto L. Leonardt, M. D.

10/21 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Columbus Ga. Via Atlanta	Oct 23 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50293

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50293

CERTIFICATE OF DEATH

1—PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. ____ ST. 1115 WARD) 14001

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Alice Barfield Holmes

(a) RESIDENCE NO. 1109½ N. Charles ST., ____ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ✓ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. C. J. Holmes

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	60	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Louisville, Ky.
(State or country)

PARENTS

10 NAME OF FATHER Mr. David Barfield

11 BIRTHPLACE OF FATHER (city or town) Culpepper Co
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Jane Gilmore

13 BIRTHPLACE OF MOTHER (city or town) Yazoo,
(State or country) Miss.

14 Informant Mrs. Marie Mattingly (Daughter)

(Address) 1109½ N. Charles St.

15 Filed ____, 19__ C. HAMPSON JONES, M. D. Registrar

By ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1927, to Oct. 21, 1929, that I last saw her alive on OCT. 21, 1929 and that death occurred, on the date stated above, at 11.06 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ✓ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Myocardial Failure c
auricular fibrillation (duration) ____ yrs. ____ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schork, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Oct 22 1929
20 UNDERTAKER Henry H. Tenkins Sons Co	ADDRESS McCulloh & Richmond

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50294 HEALTH DEPARTMENT—CITY OF BALTIMORE 74001 E 50294

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2203 Bank Street ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Apolonia Sarnecka

(a) RESIDENCE NO. 2203 Bank Street ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Ludwik Sarnecki

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 077

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Dranka

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14

Informant Mary Krawczyk/Deughter

(Address) 2205 Bank Street

Filed OCT 22 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 29

17 I HEREBY CERTIFY, that I attended deceased from Oct 1. 29 to Oct 20. 29

that I last saw h[illegible] alive on Oct 20. 29

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

10-21-29 (Address) 801 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	Oct/24/1929

20 UNDERTAKER George A. Weber ADDRESS 705 E Lanvale St

Spec.—I-12-23—M&T—500 Blks.

E 50295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 50295

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Bernard Zelinski

(a) RESIDENCE No. 1340 Glyndon Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred (15) yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Helen Zelinski

6 DATE OF BIRTH (month, day, and year) ? 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Anthony Zeliski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Bucketais

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant, Helen Zelinski (Address) 1340 Glyndon ave

15 Filed OCT 22 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Oct 21, 1929, that I last saw him alive on Oct 21, 1929 and that death occurred, on the date stated above, at 6 25 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cardiac end of Stomach

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of 9/11/29

Was there an autopsy? Yes

What test confirmed diagnosis? Biopsy

(Signed) J Montagna, M. D.

10/21, 1929 (Address) W. Balto. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 10/24 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun & Hollins Sts

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50296

CERTIFICATE OF DEATH.

129 E 50296

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hosp 12-30 ST.) (WARD)

2-FULL NAME Madeen Hammond Jones

(a) RESIDENCE NO. 615 W Barrett ST., WARD

(Usual place of abode) Baude St

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Brother on admission (Address)

15 Filed 2 7 1929 J. HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Oct 21, 1929, that I last saw h[illegible] alive on Oct 21, 1929, and that death occurred, on the date stated above, at 12 20 m.

The CAUSE OF DEATH* was as follows:

Anemia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Chr Diffuse Glom. Nephritis

(duration) about 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

, 19 Address Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-22 1929
20 UNDERTAKER Daniel Easton	ADDRESS 716. Penn

TION IS very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50297

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50297

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 Archer ST. 21-29 WARD)

REGISTERED NO. 24-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Winfield A Wright.

(a) RESIDENCE NO. 636 Archer ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1/2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE: Years 29 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Winfield Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Viola Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Viola Wright

(Address): 636 Archer St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/29

17 I HEREBY CERTIFY, That I attended deceased from 10/15/29, to 10/21/29, that I last saw him alive on 10/21/29, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Erysipelas Septic Conjunctivitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Dann M. D.

(Address) 727 Wood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-22 1929
20 UNDERTAKER	ADDRESS
Daniel Corbin	916 Pa ave.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 30117 E 50298 — 44 E 50298

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julius Bender

(a) RESIDENCE NO. 331 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced, (write the word)~~
male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book binder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Maurice Liberman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Marian Bender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 12-2 1928, HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19/29

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1929, to October 19, 1929, that I last saw h~~im~~ alive on October 19, 1929, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Ca of Stomach

Pul Operative Bronchopneumonia

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-16-29

Was there an autopsy? No

What test confirmed diagnosis? Exploration

(Signed) [illegible] M. D.

10/21/1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel Rd	Oct 22, 1929
20 UNDERTAKER Sol Levinson & Bro	ADDRESS 1127 E Balto st

Spec.—8-16-29—L. P. S.—100 Blks.

E 50299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8 ✓ E 50299

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 736 S. Charles ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Prosen

(a) RESIDENCE NO. 736 S. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 11 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 6 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Prosen

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Edith Cohen

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14
Informant Louis Cohen
(Address) 736 S. Charles St

15
Filed OCT 22 1929 CLAYTON JONES, M. D.
Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 29

17
I HEREBY CERTIFY, That I attended deceased from Oct. 17 1929, to Oct. 21 1929, that I last saw him alive on Oct 21 1929 and that death occurred, on the date stated above, at 9 50 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. Fleis, M. D.

Oct. 22, 1929 (Address) 24 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	Oct 22 19 29
20 UNDERTAKER Sol Levinson & Bro	ADDRESS 1127 E Baltimore St

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50300

CERTIFICATE OF DEATH

129

E 50300

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1840 N Saratoga ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Meagher

(a) RESIDENCE NO. 1840 N Saratoga ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Meagher

6 DATE OF BIRTH (month, day, and year) Sept 23 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Record Office

(c) Name of employer Supreme Court

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Meagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Schott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary A. Meagher

(Address) 1840 N Fremington St

15 Filed DEC 2 1929 H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20-29

17

I HEREBY CERTIFY, That I attended deceased from Sept-30, 1924, to Oct 20, 1929

that I last saw h— alive on Oct 19, 1929

and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Uremic Convulsions
Duration

CONTRIBUTORY (Secondary) Myocarditis + Old (duration) 2 yrs mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Oct 21, 1929 (Address) 1724 N Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	10-23 1929
20 UNDERTAKER Bernard C Harkins	ADDRESS 5 Rec St

Spec.—I-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50301

CERTIFICATE OF DEATH.

E 50301

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 15-6 ST. (WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Manekin

(a) RESIDENCE No. 1642 Maryland Ave ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Manekin

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis —

11 BIRTHPLACE OF FATHER (city or town) (State or country) R.

12 MAIDEN NAME OF MOTHER Un —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) R.

14 Informant S. Manekin
(Address) 1642 Maryland Ave.

15 Filed 10 22 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17 .1929. to Oct. 21 .1929.

that I last saw h[illegible] alive on Oct. 21 .1929.

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

1 Chronic nephritis

2 Bronchopneumonia

Contributory Cardiac Decompensation

(duration) (1) 15 yrs. mo (2) 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, mitral stenosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) Dr. L. Levy M. D.

10/21, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Sinai Park

DATE OF BURIAL 10-22-1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Frankhan
E. Biddle St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50302

CERTIFICATE OF DEATH

90 V E 50302

1—PLACE OF DEATH

REGISTERED NO. 16-65

CITY OF BALTIMORE: (No. 921 N. Bentalou ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie E. Windsor

(a) RESIDENCE NO. 921 N. Bentalou ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James T. Windsor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	About 52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard J. Barron

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unkown

12 MAIDEN NAME OF MOTHER Catharine Mc Elroy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs A. J. Hohman
(Address) 921 N. Bentalou St.

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 29, to Oct 19, 29, that I last saw her alive on Oct 17, 29 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows: Myocardial failure

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) R. O. Brunk M. D.

, 19 (Address) 98 Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Oct 24 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 E Baltimore St

Spec.—2-29-2[illegible] F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50303

CERTIFICATE OF DEATH

129 ✓

E 50303

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1123 Sarah Ann ST. 18-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Etta Brookes

(a) RESIDENCE NO. 1123 Sarah Ann ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Morris Brooks

6 DATE OF BIRTH (month, day, and year): May 18, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic gp

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Lowry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Md.

12 MAIDEN NAME OF MOTHER: Barbara?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lillie Harris

(Address) 1123 Sarah Ann St

15 [illegible] HERMON JONES, M. D. Registrar

OCT 22 1929 Hyp.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1929, to Oct. 18, 1929, that I last saw her alive on Oct 18, 1929 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio renal vascular Complications

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Sals,

(Signed) H Marco Williams M. D.

Oct. 19 29 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct 22, 1929
20 UNDERTAKER: Mrs. Katie R. Williams	ADDRESS 322 N Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50304 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50304

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 120 N Dallas ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary James

(a) RESIDENCE NO. 120 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

a If married, widowed, or divorced (or) WIFE of Chas James

6 DATE OF BIRTH (month, day, and year) approx 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Brodfield

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Chas E Howard

(Address) 120 N Dallas st

15 Filed 1 2 7 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21/29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1929, to 10/21 1929, that I last saw h alive on 10/21 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis and Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs 3 mos. ds.

General Anasarca

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R L Young M. D.

10/23 1929 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL at 25 1929

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

Spec.—2-29-[illegible]—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50305

CERTIFICATE OF DEATH

10-001 VE 50305

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1713 W. Franklin ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabella Augusta Freeman

(a) RESIDENCE NO. 1713 W. Franklin ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	Col	Infant

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept 5, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Perry Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Salem, Va.

12 MAIDEN NAME OF MOTHER Florentine Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md.

14 Informant Perry Freeman
(Address) 1713 W. Franklin

15 Filed OCT 22 1929 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20. 1929, to Oct 4. 1929.

that I last saw her alive on Oct 4. 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Lab.

(Signed) H Marion Williams M. D.

10-4-1929 (Address) 1830 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary Cem	Oct 22 1929
20 UNDERTAKER	ADDRESS
Joseph A Ulrich	1911 Mad Ave

Spec.—2-29-28—L. F. S.—500 Bks.

230238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50306 — 101-001 — E 50306

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 12-19 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elton Woodfalls

(a) RESIDENCE NO. 420 E Federal ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-17-29

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Eugene Hobson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Woodfalls

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 22 1929 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 19, 1929, that I last saw him alive on Oct 19, 1929, and that death occurred, on the date stated above, at 7.48 P m.

The CAUSE OF DEATH* was as follows:

Pneumococcus meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Lumbar puncture smear

(Signed) W Blickford Jr M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS OCT 2 1929

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50307 | CERTIFICATE OF DEATH. | 161-00 E 50307

1-PLACE OF DEATH 1611 Lawrence Street | REGISTERED NO. 16-22

CITY OF BALTIMORE: (No. 1611 Lawrence St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lewis

(a) RESIDENCE NO. 1611 Lawrence St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19-10-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Child.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Whitehaven, Md.

12 MAIDEN NAME OF MOTHER Clara Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northampton Co., Va.

14 Informant Clara Turner

(Address) 1611 Lawrence St

15 Filed OCT 22 1929 H. LEON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 21/10/1929

17 I HEREBY CERTIFY, That I attended deceased from 19-10-1929. to 21-10-1929.

that I last saw him alive on 20-10-1929,

and that death occurred, on the date stated above, at about 11 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth (?)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Mayfield Boyd, M. D.

19 (Address) 624 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL: 19

20 UNDERTAKER: [illegible] Health. — ADDRESS: OCT 22 192

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

224805 E 50308 — CERTIFICATE OF DEATH — 38 E 50308

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse Griffin

(a) RESIDENCE NO. 123 N. Ballad ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 2 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 —, 1929, to Oct 16, 1929

that I last saw him alive on Oct 16, 1929

and that death occurred, on the date stated above, at 9 Am.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Syphilis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. H. Brieger, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS OCT 2 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50309

CERTIFICATE OF DEATH

3 | E 50309

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 211 N. Spring St. 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel McDonnell

(a) RESIDENCE NO. 211 N. Spring St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
about 28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Florence, S.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Ayter Faidley
(Address) 213 N. Spring St.

15 Filed OCT 22 1929 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17/29 [illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

10/21/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
UNIVERSITY OF MARYLAND	
20 UNDERTAKER Commissioner of Health	ADDRESS OCT 22 1929

THE MORGUE.

Mar. 7th E. WOODALL

Be sure CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50310

CERTIFICATE OF DEATH

E 50310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 100 N. Front St. Lurving Hond 31 St., 5 Ward)

2-FULL NAME James Ryan. James Beecher. Pat. Mc Laughlin

(a) RESIDENCE NO. 100 N. Front St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: white | 5 Single, Married, Widowed or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: 65 Years | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant
(Address)

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 about 1/2 19 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac disease
Pulmonary edema
Mary Jane Pulmonary tuberculosis.
2 years days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Fuller Carey M. D.

Oct 17 19 29 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health. — ADDRESS OCT 21 1929

OCT 21 1929 C. HAMPSON JONES, M. D.

TO THE MORGUE.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 50311 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50311

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. 1-9 ST., WARD)

2-FULL NAME Baby Wright

(a) RESIDENCE NO. Clemmers Run, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1929

7 AGE Years Months Days 1 1/2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Clinton Wright

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Estella Lewell

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant R G Douglas
(Address) Johns Hopkins Hospital

15 Filed 1929 H. Wilson Jones, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-20, 1929 to 10-21, 1929.

that I last saw him alive on 10-21, 1929.

and that death occurred, on the date stated above, at 4.01 A. m.

The CAUSE OF DEATH* was as follows:

Immaturity

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R G Douglas M.D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

UNDERTAKER Commissioner of Health.

ADDRESS OCT 2 1929

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50312

HEALTH DEPARTMENT—CITY OF BALTIMORE

74001 E 50312

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3201-E. Monument St. No. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth C. Debelius

(a) RESIDENCE NO. 3201-E. Monument St WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Debelius

6 DATE OF BIRTH (month, day, and year) 10/2/1850

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	79	—	19	18 X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leopold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alsace

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) 4

14 Informant Mrs J Debelius

(Address) 3201-E. Monument St

15 Filed ..., 19 1931 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20th 1929.

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Oct, 1929, that I last saw her alive on Oct 20th, 1929 and that death occurred, on the date stated above, at 11 59 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Ford, M. D.

, 19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	10/23/1929.
20 UNDERTAKER George J. Duffy & Son	ADDRESS 1735 Harford Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50313 46 E 50313

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE (No. 3716 Greenmount Ave ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Annie Howard

(a) RESIDENCE NO. 3716 Greenmount Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed or divorced HUSBAND of (or) WIFE of Wyatt D. Howard

6 DATE OF BIRTH (month, day, and year) Sept. 1 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Warren H. Shane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Annie Kraemer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wyatt D. Howard

(Address) 3716 Greenmount Ave

15 Filed OCT 22 1929 E. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1929, to Oct. 20, 1929, that I last saw ~~him~~ alive on Oct 20, 1929 and that death occurred, on the date stated above, at ~~5~~ 7.45 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary —

— (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. L. Gray —, M. D.

10/21/29 (Address) 622 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 23 1929
UNDERTAKER Wm. J. Tickner Sons	ADDRESS W. & Pa.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50314

CERTIFICATE OF DEATH

99-001

E 50314

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2603 Penna. Av ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Elizabeth Catherine Meister

(a) RESIDENCE NO. 2603 Penna Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	Wht	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Charles J. Meister

6 DATE OF BIRTH (month, day, and year) Oct 31/1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Fred. Reuter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Emp. Medico (on) (Address) 2617 Penna. Av.

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

OCT 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21/29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1929, to Oct 21, 1929, that I last saw her alive on Oct 20, 1929 and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Right bronchitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Heart Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E. Edmonds, M. D.

10/31, 1929 (Address) 1605 Maryland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct. 23 1929
20 UNDERTAKER Wm. F. Tuckner Sons	ADDRESS N. Y. Pa

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50315

CERTIFICATE OF DEATH.

91-002 E 50315

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1 ST. 69 WARD)

2-FULL NAME Jacob H. ~~Blocher~~ Blocher

(a) RESIDENCE NO. Manchester Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of or ~~WIFE of~~ Martha J Blocher

6 DATE OF BIRTH (month, day, and year) 11-19-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John M Blocher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Rubl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant J Harry Blocher

(Address) Hampstead Md

15 Filed OCT 22 1929 C. HALSEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct. 21, 1929.

that I last saw him alive on Oct. 20, 1929.

and that death occurred, on the date stated above, at 6 50 P.M.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

Arteriosclerosis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Post Operative Shock

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/20/29

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Wm B. Wallace M. D.

1 Nov 1929 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Manchester Md. DATE OF BURIAL Oct 24 1929

UNDERTAKER: E. O. Tipton ADDRESS Hampstead Md

THIS IS very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 50316

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5627 Greenhill Ave ST. 36-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie V. McGann

(a) RESIDENCE NO. 5627 Greenhill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of William P. McGann

6 DATE OF BIRTH (month, day, and year) Nov. 30-1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
47	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Boland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Susan Canby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Wm. J. McGann

(Address) 5627 Greenhill Ave.

15 Filed OCT 22 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20/29

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1929, to Oct 20, 1929, that I last saw h[er] alive on October 19, 1929 and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Grunal metastasis

CONTRIBUTORY (Secondary) (duration) 1 yrs. mos. ds.

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 23/1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Ruck, M. D.

10/24. 1929 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Oct. 23 1929

UNDERTAKER Leonard J. Ruck

ADDRESS 6405 Lefton Ave. Hamilton

Spec.—2-29-28—L. F. S.—500 Blks.

E 50317

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 50317

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospls. REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST., 11-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rufus Eland

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) Balto City Hospls

15 Filed Oct 22, 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-19-29

17

I HEREBY CERTIFY, That I attended deceased from 9-29-, 1929 to 10-19, 1929

that I last saw him alive on 10-19-, 1929

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

Luetic Infection (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) Harry Feldman M. D.

10-21-1929 (Address) Balto City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL Oct 22 1929

20 UNDERTAKER Commissioner Health.

ADDRESS

Spec.—I-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50318

CERTIFICATE OF DEATH.

E 50318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 N. Calvert ST. 11-15 WARD) 16-502

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Buck Wing

(a) RESIDENCE NO. 807 N. Calvert ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Chinese	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chuck Doo Wing

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Lee Shee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant

(Address)

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 22, 1929,

that I last saw h alive on Oct 22 29, 19,

and that death occurred, on the date stated above, at 6 AM m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Long, M. D.

Oct 23 19 29 (Address) 702 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL Oct 22 1929

20 UNDERTAKER [illegible] — ADDRESS

(Signed) Commissioner of Health.

SEE IMPORTANT INSTRUCTIONS ON BACK OF CERTIFICATES.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50319

CERTIFICATE OF DEATH

90 E 50319

1-PLACE OF DEATH St. Mary's Star of the Sea Church

City of Baltimore: (No. Riverside Ave & Clement St. 24-33 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Denny.

(a) RESIDENCE NO. 1209 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do nog know.

7 AGE	Years	Months	Days	IF LESS than 1 day.... hrs. or .... min.
	65	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) City Highway Dept.
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Do not know

12 MAIDEN NAME OF MOTHER
Do not know

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Do not know.

14 Informant Robert Fraley.
(Address) 118 E. Gittings St.

Filed ..... 19.....

C. HAMPSON JONES, M. D. Registrar

2 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) _____

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1209 Light St.

Did an operation precede death? No. Date of _____

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Abell Fenwick, M. D.

10/22 19 29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	10/23/1929
20 UNDERTAKER [illegible]	ADDRESS 5 [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-24-14—M. & T.—3000 blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50320

CERTIFICATE OF DEATH.

E 50320

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 N Broadway ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Masters

(Residence in Baltimore: No. 1735 N Broadway St.; ..... yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct 21, 1929
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. ..... da.

If LESS than 1 day, 9 hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), 1735 N Broadway

PARENTS.

10-NAME OF FATHER, Clifford Masters

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lillian Yost

13-BIRTHPLACE OF MOTHER (State or Country), W. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clifford Masters

(Address) 1735 N Broadway

15-

Filed ..... C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21, 1929.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 21 1929, to Oct 21 1929, that I saw h[illegible] alive on Oct 21 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) Life yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... da.

(Signed) Ralph L. Wolf M. D.

Oct 21, 1929 (Address) 726 Orleans St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health.

ADDRESS OCT 22 1929

FOR: WM. K. WOODALL

Important. See instructions on back of certificate.

7-2-190[illegible] 3995

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50321

CERTIFICATE OF DEATH

74-001 ✓

E 50321

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3429 Hudson ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kunigunda Patzwall.

(a) RESIDENCE NO. 3429 Hudson ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married Single

5a If married, widowed, or divorced BUSBAND of (or) WIFE of August Patzwall

6 DATE OF BIRTH (month, day, and year) April 29th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Wachter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant August Patzwall

(Address) 3429 Hudson St.

15 ....., 19 .....

Registrar

22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/29

17

I HEREBY CERTIFY, That I attended deceased from Oct. 17 -, 1929, to Oct 19, 1929.

that I last saw h er alive on Oct - 19 -, 1929

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage.

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) N. J. Davidson, M. D.

, 19 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Oct 23 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	403 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50322

CERTIFICATE OF DEATH

E 50322

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 605 S. Bouldin ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Hammann

(a) RESIDENCE NO. 605 S. Bouldin ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lorenz Hammann

6 DATE OF BIRTH (month, day, and year) [illegible] 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of indostry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Guenther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lorenz Hammann

(Address)

15 [illegible], 19 [illegible]

2 2 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from August 30, 1929, to Oct 20, 1929

that I last saw h[illegible] alive on Oct 20, 1929

and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Willem J Rydstone M. D.

, 19 (Address) 502 N Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Hearts Cem't	Oct 23 1929
20 UNDERTAKER	ADDRESS
Lilly Zilon INC.	403 S. Wolfe

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50323

CERTIFICATE OF DEATH

90 E 50323

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Full.

City of Baltimore: (No. Mosher & Poplar Ave. St., 25-75 Ward)

2-FULL NAME Michael J Lightner

(a) RESIDENCE NO. 3641 Leo St E. Brooklyn St... Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta E.

6 DATE OF BIRTH (month, day, and year) Oct 25 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
69	68	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jacob Lightner

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Hinkemeyer

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Augustus E Lightner
(Address) 3641 Leo St.

Filed 19

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leo Lusk M. D.

Oct. 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct 24 1929
20 UNDERTAKER	ADDRESS
Fillo Zibro Inc	4038 W Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2 2 1929

KPH

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50324

CERTIFICATE OF DEATH

181-001 V

E 50324

1-PLACE OF DEATH

City of Baltimore: (No. 713 W. Fayette St., 4-7th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank E. Linden.

(a) RESIDENCE NO. 713 W. Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Christina Linden

6 DATE OF BIRTH (month, day, and year) April 18-1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Auto. Club of Md.

9 BIRTHPLACE (city or town)
(State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER John Linden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Christina Linden
(Address)

15 Filed Oct 21 1929 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20-1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Poisoned by Carbon Monoxide Illuminating Gas. Accidental Death (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

10/22. 1929. (Address) 2739 Easterwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Oct 23 1929

20 UNDERTAKER Fred. Lossa Inc & Sons — ADDRESS Fullerton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 50325

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3713 Elairmount ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Madeline Rose Brown

(a) RESIDENCE NO. 3713 Elairmount ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 11 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William E. Brown

6 DATE OF BIRTH (month, day, and year): Nov. 20th 1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
28	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry Schuman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Roll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William E. Brown (Husband)
(Address) 3713 Elairmount

15 Filed ..., 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 21st 29

17 I HEREBY CERTIFY, That I attended deceased from Jany 2, 1929, to Oct 21, 1929, that I last saw her alive on Oct 21, 1929 and that death occurred, on the date stated above, at 10 25 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cardio respiratory Paralysis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings-Exam

(Signed) J. V. Clift M. D.

Oct 22 1929 (Address) 3532 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Oct. 24th 1929
UNDERTAKER: Lilly & Zeiler Inc.	ADDRESS: 403 S. Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

E 50326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50326

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1606 Guilford Av St. 12-19 Ward)

2-FULL NAME Solomon Tripp

(a) RESIDENCE NO. 1606 Guilford St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
Abt 5-3			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) Jno Barley 07
(c) Name of employer

9 BIRTHPLACE (city or town) Va. Smith
(State or country) ?

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mrs Mary Ann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Police Dept
(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

2 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21-29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Sent Years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Bailey Coroner M. D.

Oct 27 19 29 (Address) 1639 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pa	10/23 19 29
20 UNDERTAKER J. F. Schuyler & Sons	ADDRESS 131 S Eighth St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50327 ✓ 29 E 50327

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 24-32 Ward)

2-FULL NAME Julian Wood

(a) RESIDENCE NO. 119 E. Cross St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1-1919

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	9	11	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At school
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Frank Woods

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Grumby

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Frank Wood
(Address) 119 E Cross St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Tetanus

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 119 E Cross St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.

10/22. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	10/24 1929
20 UNDERTAKER	ADDRESS
A. Howard Evans	3[illegible] Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50328

CERTIFICATE OF DEATH

51 E 50328

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 718 Newington Ave. ST. 13-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte Anderfuhren

(a) RESIDENCE NO. 718 Newington Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Anderfuhren

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Windecken
(State or country) Germany

PARENTS

10 NAME OF FATHER William Schmitt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany ?

14 Informant Miss Lottie Anderfuhren
(Address) 718 Newington Ave.

15 Filed 2 3 1929 16 [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1929, to Oct 20, 1929 that I last saw her alive on Oct 20, 1929 and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes - arteri-sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lantz, M. D.

Oct 21, 1929 (Address) Temple Gardens Apt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 23 1929
20 UNDERTAKER [illegible]	ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50329

CERTIFICATE OF DEATH

+ 44 ✓

REGISTERED NO. E 50329

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 12-49 (WARD)

2—FULL NAME Thomas Kalbach

(a) RESIDENCE NO. West Seelyport, Penna ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Nov 18, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Nathaniel Kalbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Amelia Clauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs Thomas Kalbach

(Address) Leesport Pa

15 [illegible] JONES, M. D. Registrar

OCT 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 23, 1929,

that I last saw him alive on Oct 23, 1929

and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Post operative shock
(Carcinoma stomach 3 mos)

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 20? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Penna

Did an operation precede death? Yes Date of Oct 21

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) James Arthur Weenberg, M. D.

10/23/1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leesport Penna.	10/23 1929
20 UNDERTAKER John F. Kenny	ADDRESS 715 Light St

Spec.—8-16-29—L. F. S.—100 Bks.

E 50330

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 ✓ E 50330

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 643 N. Eutaw ST. 1125 WARD)

2—FULL NAME Annie E. Necker

(a) RESIDENCE NO. 643 N. Eutaw ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 10 mos. 7 ds. How long in U. S., If foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob J. Necker

6 DATE OF BIRTH (month, day, and year) Dec. 13/1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Bode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Yeager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob J. Necker

(Address) 643 N. Eutaw St

15 Filed OCT 23 1929 10 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Oct 20th, 1929, that I last saw h-m alive on Oct 20, 1929 and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1928

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B. Kadow, M. D.

10/21. 1929 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Oct. 23 1929
20 UNDERTAKER	ADDRESS
Chas. E. Franch	802 Madison Ave

Spec.—1-12-23—M&T—500 Bks.

50331

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

10-C 50331

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Jackson

(a) RESIDENCE NO. 1424 Hemple ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Lucy Jackson (on admission)
(Address) 1424 Hemple alley

15 Filed OCT 23 1929 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-29 19

17

I HEREBY CERTIFY, That I attended deceased from 10-17-29, 19, to 10-21-29, 19,

that I last saw her alive on 10-21-29, 19,

and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs about 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) George McDonald, M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury

DATE OF BURIAL Oct 23 1929

20 UNDERTAKER John W Henderson

ADDRESS 1501 E. Monument

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50332 — 188-103 — E 50332

1-PLACE OF DEATH — REGISTERED NO.

City of Baltimore: (No. Franklin Sy Hos 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter I Levian

(a) RESIDENCE NO. 25 N. Bentalou St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Feb 10 - 1903

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	26	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Base ball player
(b) General nature of industry, business, or establishment in which employed (or employer): Sports
(c) Name of employer: Phila Nat. League 086

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jacob H Levian

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Josephine Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Josephine Levian
(Address): 25 N Bentalou

Filed 10-23 1929 C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Concussion abdomen with visceral Heamorrhage & possible fract pelvis - knocked down by auto & crushed against wall and it (demolishing wall)

CONTRIBUTORY (Secondary) Visceral Heamorrhage traumatic (duration) yrs. days mos. ds.

18 Where was disease contracted If not at place of death? Mount & Fayette

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. J. Frame M. D.

10 23 1929 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Orchard Cemetery	10/24/29
20 UNDERTAKER: Geo A Fuhrman	ADDRESS: Frederick Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001 E 50333

1—PLACE OF DEATH

REGISTERED NO. 17-24

CITY OF BALTIMORE: (No. 1133 Argyle Ave (WARD) 11)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Butts

(a) RESIDENCE NO. 1133 Argyle Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Lewis Butts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Hutcoon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hutcoon

14 Informant: Ernest Butts

(Address) 632 N. Lee St.

15 Filed ..., 19... C. HAMPSON JONES, Registrar

23 1929 Roll

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 19-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Oct 19, 1929, that I last saw h.. alive on Oct 19, 1929, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 4 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. K. Gossage, M. D.

Oct 22, 1929 (Address) 417 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10/23/1929

20 UNDERTAKER: Samuel Dewsbury ADDRESS: 578 N. Biddle

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 50334

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50334

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 136 East SD. St., 5-8 Ward)

2-FULL NAME Richard R. Hill

(a) RESIDENCE NO. 136. East St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martina Hill

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Md. Lumber Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER Abe Hill

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Martina Hill
(Address) 136 East St

Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

T 23 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries Received
Struck by Automobile
(duration) yrs. mos. ds.
Fractured Skull
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Pilley Coroner, M. D.

Oct 24, 1929 (Address) 1634 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	10-23 1929
20 UNDERTAKER	ADDRESS
Byron Wright	1218 McCulloh St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 50335

REGISTERED NO.

I—PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Asquith ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Cook

(a) RESIDENCE NO. 207 Asquith ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Widow

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Cook

6 DATE OF BIRTH (month, day, and year) July 20 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Joseph Cook

(Address) 2031 McCulloh St

15 Filed ... C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/20/24

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 24, to 10/20 19 24, that I last saw h. alive on Oct 19 19 24 and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage.
2 Hemiplegia

CONTRIBUTORY (Secondary) Epileptic attacks and Hypertension (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) L. Y. Bruby, M. D.

10/20 19 24 (Address) 1 E 24 E Lawrence St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL Oct 24 1924

20 UNDERTAKER Theodore G White

ADDRESS 1015 Poe St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50336

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 50336

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospt. REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md. ST. 22-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carmen Thompson

(a) RESIDENCE NO. 804 William St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 1 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Thompson.

6 DATE OF BIRTH (month, day, and year) Sept 14 - 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39		1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Acton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records (Address) Balto City Hosp.

15 Filed 12-3 1929 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21-29

17 I HEREBY CERTIFY, That I attended deceased from 6-4, 1929, to 10-21, 1929

that I last saw her alive on 10-21, 1929

and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio Pneumonia

Massive Collapse of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Involutional Melancholia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) How To Dr. M. D.

10/24, 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	10/24 1929
20 UNDERTAKER	ADDRESS
J. Frew McCully	130 E. Fort

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50337

CERTIFICATE OF DEATH

× 44 ✓

E 50337

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Allender

(a) RESIDENCE NO. Chase Md ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Josh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Rosetta Bans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed OCT 23 1929, WILLIAM H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 20-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Oct 20, 1929, that I last saw him alive on Oct 20, 1929, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 21 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Chase, Md.

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) J. R. Trimble, M. D.

Oct 24, 1929 (Address) J H Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chase Md.	Oct. 23 1929
UNDERTAKER: Mrs. P. A. Elliott	ADDRESS: Parkland

Spec.—2-29-28—L. F. S.—500 Bks.

E 50338

HEALTH DEPARTMENT—CITY OF BALTIMORE

21-09

E 50338

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 16-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernard J. Russell

(a) RESIDENCE NO. 400 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 7 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	7 8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bart J. Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Garnet Snapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Bart J. Russell

(Address) 400 N. Fremont St.

15 Filed 10-23-1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929, to Oct 21, 1929, that I last saw h in alive on Oct 21, 1929 and that death occurred, on the date stated above, at 11 25 p m.

The CAUSE OF DEATH* was as follows:

Streptococcic Meningitis

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 400 N. Fremont St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical findings + Spinal puncture

(Signed) Addison Craft Irby M. D.

10-22-1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls. Violetville	10-24 1929
20 UNDERTAKER	ADDRESS
Mrs Chas A G Rohde	2327 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

E 50339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50339

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. In Garage near 4710 Hudson St., 28-63 Ward)

2-FULL NAME Carl Peterson

(a) RESIDENCE NO. 4710 Hudson St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ethel N. Peterson

6 DATE OF BIRTH (month, day, and year): Feb 15 1867

7 AGE: Years 42 Months 8 Days 16 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Manager of
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Merchants Terminal

9 BIRTHPLACE (city or town): Drummonds
(State or country)

PARENTS

10 NAME OF FATHER: Peter Jensen

11 BIRTHPLACE OF FATHER (city or town): Denmark
(State or country)

12 MAIDEN NAME OF MOTHER: Mathilda

13 BIRTHPLACE OF MOTHER (city or town): Denmark
(State or country)

14 Informant: Ethel N. Peterson
(Address): 4710 Hudson St.

15 Filed Oct 26 1929, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Examination

(Signed) Edward Schmuck M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Hope Cemetery Rochester N.Y. DATE OF BURIAL: Oct 26 1929

20 UNDERTAKER: Edmund W. Conklin ADDRESS 1242 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50340 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 50340

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave St. 4-28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Ulrich

(a) RESIDENCE No. 215 S. Mount St, Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Ulrich

6 DATE OF BIRTH (month, day, and year) Feb 3rd 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore Mason

(b) General nature of industry, business, or establishment in which employed (or employer) Fellheimer Sons

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Ulrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Hirschmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Mamie Ulrich

(Address) 215 S. Mount St

Filed 23 1929 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-21 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 17th, 1929, to Oct 21st, 1929, that I last saw h[illegible] alive on Oct 21st, 1929 and that death occurred, on the date stated above, at 2^10 P m.

The CAUSE OF DEATH* was as follows:

~~Hypertension~~ - Paralysis

Hemiplegia, Cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? N.A.

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral | DATE OF BURIAL Oct 24 1929

20 UNDERTAKER L. Weisert | ADDRESS 1050 N. Patterson Park Ave

THON is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50341

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 N. Broadway ST., 817 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura V. Scherer

(a) RESIDENCE NO. 1533 N. Broadway ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Scherer

6 DATE OF BIRTH (month, day, and year) June 15-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edwin Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Haney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Edwin F. Price

(Address) 1306 Longfellow St. N.W.

15 Filed ... 19 ... Washington, D.C.

T 23 1929 [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20-1929

17

I HEREBY CERTIFY, That I attended deceased from 10/17, 19 29, to 10-20, 19 29,

that I last saw h[illegible] alive on Oct 20, 19 29

and that death occurred, on the date stated above, at 11 P 1 m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration & hypertension

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) David Weber, M. D.

10/21, 19 29 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Oct 23 19 29

20 UNDERTAKER George W. Zibler

ADDRESS 1737 E. Eager st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50342

CERTIFICATE OF DEATH

16-002

E 50342

1-PLACE OF DEATH

City of Baltimore: (No. 1211 Mosher St., 16-23 Ward)

2-FULL NAME Estella Robinson.

(a) RESIDENCE NO. 1211 Mosher St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Robinson

6 DATE OF BIRTH (month, day, and year) June 13 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John West.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Matilda Mathews

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mayme Bridges
(Address) 1211 Mosher

15 Filed ....., 19.... HARRISON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 20th 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dysentery 5 d.

yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Endocarditis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leland Conner, M. D.

(Address)

Oct. 20th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Mt. Auburn	Oct 23 27
20 UNDERTAKER	ADDRESS
John H. Jordan	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

23 1927

Spec.—2-29-28—L. F. S.—500 Bks.

E 50343

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50343

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Calvin Rogers

(a) RESIDENCE NO. 202 Myrtle Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs 0 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

a If married, widowed, or divorced HUSBAND of (nr) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or.. min.
	3	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child - died

(b) General nature nf industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER William Rogers

11 HIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maggie Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Maggie Rogers

(Address) 202 Myrtle Ave

15 Filed OCT 23 1929 HARRY H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Oct 23, 1929 that I last saw him alive on Oct 22, 1929 and that death occurred, on the date stated above, at 6 35 a m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho - pneumonia

(duration) 0 yrs 0 mos 5 ds.

18 Where was disease contracted if not at place nf death? 202 Myrtle Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings + X ray

(Signed) Addison Corbett M.D. M. D.

10-23 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-23 1929
20 UNDERTAKER David Corbin	ADDRESS 816 Fremont Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓ E 50344

E 50344

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto Co Hosp 16-22 St. Ward)

2-FULL NAME Rosetta Reynolds

(a) RESIDENCE NO. 1511 Fulton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Colur or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employd (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Co

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) md

14 Informant Flora Dennis
(Address) 1511 Fulton St

Filed OCT 23 1929 HAMPSON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry find that said deceased came to Her death
(Inquest, autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) — yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-23-29
20 UNDERTAKER Dennett Carter	ADDRESS 916 Eager

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 50345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-22 161-001 E 50345

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 16 WARD)

2-FULL NAME Baby Girl Holmes

(a) RESIDENCE NO. 526 N. Pironet St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: B.

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13/29.

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day, / hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None. ..... (b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Henry Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mildred Muse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mother

(Address) .....

Filed Oct 23 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Oct 13, 1929, that I last saw h[illegible] alive on Oct 13, 1929, and that death occurred, on the date stated above, at 2 20 m.

The CAUSE OF DEATH* was as follows:

Prematurity.

28 wks

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

10/23 1929 (Address) Mat. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS .....

OCT 23 1929

C. HAMILTON [illegible], M. D.

[illegible]

CAUSE OF DEATH must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50346 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50346

CERTIFICATE OF DEATH.

1-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Mrs. Geo. W. Bottinger

(a) RESIDENCE NO. 944 W. Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~) Barbara Bottiger

6 DATE OF BIRTH (month, day, and year) July 14 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	71	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Barbara Bottiger 944 W Lexington St

15 Filed 2 3 1929 C. HAMILTON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1929.

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 21, 1929.

that I last saw h alive on Oct 21, 1929.

and that death occurred, on the date stated above, at 2-10 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(duration) yrs mos ds

CONTRIBUTORY (Secondary) Pulmonary Edema.

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture.

(Signed) D. A. Alessi, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 24 1929
20 UNDERTAKER	ADDRESS
George J. Smith	1532 Hollins

THIS is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50347

CERTIFICATE OF DEATH

90 E 50347

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 W. Lafayette Ave ST., 17 WARD)

2—FULL NAME Norvle Brookens

(a) RESIDENCE NO. 1112 W Lafayette Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): not known

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8, 1892.

7 AGE: 37 Years | 6 Months | 13 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Thadus Brookens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Pinkey West

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Bessie Fields

(Address) 1112 W. Lafayette Ave

15 Filed OCT 23 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1929, to Oct 21, 1929, that I last saw h[illegible] alive on Oct 21, 1929 and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel K Hoff, M. D.

Oct 24 1929 (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet

DATE OF BURIAL: 10/24 1929

UNDERTAKER: F. E. Kelson

ADDRESS: Preston St

Cor.—10-10-29—A Co.—100 Bks.

50348

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-105

E 50348

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St., 26-36 Ward)

2-FULL NAME Wm F. Harris - (entered as Wm F. Knysh)

(a) RESIDENCE NO. Camp Holabird St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 3-1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) U S Army do
(c) Name of employer U S A

9 BIRTHPLACE (city or town)
(State or country) Laredo Texas

PARENTS

10 NAME OF FATHER Geo W Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Ida M Hann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Record
(Address) Camp Holabird

15 Filed , 19 HARRY JONES, Registrar

OCT 23 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:
Fract (Comp. comm) skull ran into side of moving auto his head struck Handle front door (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Easton Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. F. Hann M. D.

(Address) 2939 Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	Oct 23 1929
20 UNDERTAKER	ADDRESS
Sol Levinson & Bro	112 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50349

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50349

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 18 ST. 39 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Banks

(a) RESIDENCE NO. 103 Hayes st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Mack Strotter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed 2 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1929, to Oct. 20, 1929, that I last saw him alive on Oct. 20, 1929 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas G Arnold M. D.

10-21 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	October 24 1929
20 UNDERTAKER	ADDRESS
J. Joseph Oakley	409 N Mount St

IMPORTANT.—See INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50350

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 604 Venerable Av ST., 4-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Calorke

(a) RESIDENCE NO. 604 Venerable Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Calorke.

6 DATE OF BIRTH (month, day and year) December 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) County Limerick (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Alice Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs J Talbott

(Address) 604 Venerable Av

15 Filed 2 3 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 21 / 29

17

I HEREBY CERTIFY, That I attended deceased from Oct 19th, 19 29, to Oct 21st, 19 9, that I last saw h[illegible] alive on Oct 21st, 19 9 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis & Endocarditis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

10/21/19 29 (Address) 40 E 25 St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct 24 19 29
20 UNDERTAKER	ADDRESS
Mary M Medaid	501 E 22 d

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50351

CERTIFICATE OF DEATH

129 ✓ E 50351

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 331 E 25th " ST. (WARD) 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theodore A Krauss

(a) RESIDENCE NO. 331 E 20th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nellie Cashmeyer

6 DATE OF BIRTH (month, day, and year) 1-30-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Krauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Baltimore

12 MAIDEN NAME OF MOTHER J Schuhmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Nellie Cashmeyer Krauss

(Address) 331 E 20th St

15 Filed 2 3 1929, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to Oct 21, 1929, that I last saw h[illegible] alive on Oct 21, 1929 and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights disease (Myocarditis + Nephritis)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Insanity

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

Oct 23, 1929 (Address) 624 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct 24 1929
20 UNDERTAKER	ADDRESS
Mary M Woodyard	331 E 25th

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50352

CERTIFICATE OF DEATH.

44 E 50352

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 1909 N. Lafayette ave Ward 6-22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Oldham

(a) RESIDENCE NO. 1909 N. Lafayette ave. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Nov. 6th 1871

7 AGE — Years: 57 | Months: 11 | Days: 16 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Jas. Oldham

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Louise Hinton

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto. Md.

14 Informant: Mrs Florence McKee

(Address): 1909 N. Lafayette ave

23 1929 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 22 1929

17 I HEREBY CERTIFY, That I attended deceased from July 16 1929, to Oct 22, 1929, that I last saw h.. alive on Oct 22, 1929, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows: Cancer of liver & Stomach with Metastasis to Lungs & pleura and abdomen

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & History

(Signed) Edith Long, M. D.

10/23 1929 (Address) 906 N. Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. Date of Burial Oct 24 1929

20 UNDERTAKER: Margaret G. Flynn ADDRESS 1422 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

E 50353 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50353

CERTIFICATE OF DEATH. 57

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Broadway ST., 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Blanche Robinson

(a) RESIDENCE No. Sylvest Apts. ST., WARD

(Usual place of abode) Park Ave & Whitelock St

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Robinson

6 DATE OF BIRTH (month, day, and year) Feb. 14 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Max Messinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Prag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Irvin Robinson (Address) Sylvest Apts

15 Filed . 19 Registrar

23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22 1929

17

I HEREBY CERTIFY, That I attended deceased from 9/25 . 1929 . to 10/22 . 1929 .

that I last saw her alive on 10/22 . 1929 .

and that death occurred, on the date stated above, at 7:50 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency & Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory & Clinical Exam

(Signed) Dr Cohen M. D.

. 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	10/24 1929
20 UNDERTAKER David Sandheim	ADDRESS Belmont Royal Ave

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50354 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ E 50354

CERTIFICATE OF DEATH. 179

1-PLACE OF DEATH Louis John REGISTERED NO.

CITY OF BALTIMORE: (No. Sinai Hosp. St. 7-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Louis John

(a) RESIDENCE NO. Sinai Hospital Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Abraham John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E. Mehlinger (Address) 232 Eutaw Place

15 Filed 2 3 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22, 19 29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 19 29, to Oct 22, 19 29.

that I last saw him alive on Oct 22, 19 29,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Cardiac decompensation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio vasc. renal disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harold J Sandler, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Back River Cemetery — DATE OF BURIAL 10/24/1929

20 UNDERTAKER J Johnson — ADDRESS 2432 Reisterstown Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50356 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ × 129 E 50356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO. .....

CITY OF BALTIMORE: (NO. Howard & Madison ST. 11-4-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Flora Bowles

(a) RESIDENCE NO. Franconia N. H. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	1

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) July 14, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Northfield, Mass.

PARENTS

10 NAME OF FATHER Cyrus Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record (Address)

15 FILED 2 3 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 23, 1929, that I last saw h[illegible] alive on Oct 23, 1929, and that death occurred, on the date stated above, at 7[illegible] a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis ? !
Uraemia (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) N. E. Rupprecht M. D.

Oct 23 1929 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Littleton N. H. DATE OF BURIAL Oct 23 1929

20 UNDERTAKER Harry H. Witzke ADDRESS 1531 W. Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 50356

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-09

E 50356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 S. Ann Street ST 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rozalia . Jankowiak

(a) RESIDENCE NO. 802 S. Ann Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep. 4 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John . Nowakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine . Beyma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Mary . Weber Daughter

(Address) 401 S. Chester Street

15 Filed 2 3 1929, 19 Reg. 4011 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1929, to Oct. 22, 1929, that I last saw her alive on Oct. 22, 1929, and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —.

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Krager M. D.

, 19 (Address) 26 E. Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Oct. 26 1929 19

20 UNDERTAKER John M. Weber ADDRESS 401 S. Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E.50357

HEALTH DEPARTMENT—CITY OF BALTIMORE

E.50357

CERTIFICATE OF DEATH.

101-8

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Andrea ST. 24-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Trochimowicz

(a) RESIDENCE NO. 1417 Andrea ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stanislus Trochimowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Michalska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Biloxi Miss.

14 Informant Stanislus Trochimowicz

(Address) 1417 Andrea St.

23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1929, to Oct. 22, 1929, that I last saw h/he alive on Oct. 22 1929, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary)

..... (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No Physical + Labor.

What test confirmed diagnosis?

(Signed) H. Oleary M. D.

Oct. 1929 (Address) 1430 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL 24 1929

20 UNDERTAKER John M Weber & Son

ADDRESS Chester Pa.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50358

CERTIFICATE OF DEATH

23 E 50358

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 9-46 ST., WARD)

2—FULL NAME Carolyn Eck

(a) RESIDENCE NO. 1935 E 31st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Melvin Eck

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida Bell

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Melvin Eck
(Address) 1935 E 31st St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

2 3 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from 9-28, 1929, to 10-23, 1929.

that I last saw her alive on 10-23, 1929

and that death occurred, on the date stated above, at 9 40 A. m.

The CAUSE OF DEATH* was as follows:

Probable Encephalitis Lethargica

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Hyde, M. D.

10/23, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	10/25 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 Ly Charles

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50359 | CERTIFICATE OF DEATH | 129 E 50359

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Anna Hagan

(a) RESIDENCE NO. 3057 Mathew ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elbridge Hagan

6 DATE OF BIRTH (month, day, and year): March 1862

7 AGE — Years: 67 — Months: 7 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Reiter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Elbridge Hagan
(Address) 513 - 48th St Harbor View Md

15 Filed Oct 23 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1929. to Oct 23, 1929
that I last saw her alive on Oct. 23, 1929
and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arterio-sclerotic Cardio Vascular Renal disease (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James H. Hilliard M. D.

. 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: 10/25 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Bowman Book 626 N Gilmor

E 50360

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 50360

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2325 N. Calvert ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia A. Schumacher

(a) RESIDENCE NO. 2325 N. Calvert ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 16. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Conrad Schumacher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lois Polk Durnby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Emma L. Schumacher

(Address) 2325 N. Calvert St

15 Filed ..., 19... Registrar

10 23 1929 ARR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1929, to Oct 23, 1929, that I last saw h[illegible] alive on Oct 22, 1929 and that death occurred, on the date stated above, at 7.30 9 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. dis.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bowman Lord, M. D.

10/23. 1929 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: 10/25 1929

20 UNDERTAKER: J. M. Cook — ADDRESS: 1317 E. Paul St

IMPORTANT.—SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-12-23—M&T—500 Blks.

E 50361 HEALTH DEPARTMENT—CITY OF BALTIMORE 10-001 E 50361

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4802 Park Heights ST. 27-56 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Parks

(a) RESIDENCE NO. 4802 Park Heights Ave ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R. Parks

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sandy Spring Md

PARENTS

10 NAME OF FATHER William H. Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna B. Richardson (Address) Essex Md

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1929, to Oct 23, 1929.

that I last saw h[illegible] alive on Oct 22, 1929.

and that death occurred, on the date stated above, at 10 20 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 6 yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. N. Duvall, M. D.

(Address) 1617 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	10/25 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

17 E 50362

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Hospital for Women of Md. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Bertha Mary Quinn

(a) RESIDENCE NO. 100 Cold Spring Lane WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 7 mos. 7 ds. How long in U. S., if foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dr. Hugh Young

9 BIRTHPLACE (city or town) Clooeen, Sligo Co., (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Quinn

11 BIRTHPLACE OF FATHER (city or town) Clooeen, Sligo (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Crane

13 BIRTHPLACE OF MOTHER (city or town) Clooeen, Sligo (State or country) Ireland

14 Informant Martin Quinn

(Address) 212 E. Eager St

15 Filed OCT 24 1929, 19..

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1929, to Oct. 22, 1929.

that I last saw h.. alive on Oct. 22, 1929

and that death occurred, on the date stated above, at 7.12 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) 5 min. yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis Rt. Femoral Vein following operation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hosp. for Women of Md.

Did an operation precede death? Yes Date of Oct. 17, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. G. Woodyear, M. D.

, 19 (Address) Emmitsburg, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/25 1929
20 UNDERTAKER	ADDRESS
H. W. Mears & Son	805 N. Calvert St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 50363

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Maryland Ave Hosp-59 St., Ward)

2-FULL NAME Rachal Kellert

(a) RESIDENCE NO. 2240 Brookfield Ave., St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Kellert

6 DATE OF BIRTH (month, day, and year) ------- 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Morris Kerr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Samuel Kellert
(Address) 2240 Brookfield Ave.,

15 Filed ....., 19..... [illegible] JONES, M. D. Registrar

T 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22-29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull - compound
Runaway by Bus.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Crushed Chest

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Reservoir nr Brookfield

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Frann M. D.

10/23 19 9 (Address) 2939 W. Eldery

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shaw Friendship	10-24 19 29
20 UNDERTAKER	ADDRESS
Jos. Lewis	1439 E. Balto. St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50364

REGISTERED NO. 27-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home for Aged) (WARD) Baltimore

2-FULL NAME Jennie Meizner

(a) RESIDENCE NO. Hebrew Home for the Aged & Infirm WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant L. Lewis
(Address) 1432 E Balto St

15 Filed CT 24 1929 H. LEVERTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1929.

17

I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Oct 23, 1929, that I last saw her alive on Oct 21, 1929 and that death occurred, on the date stated above, at 3 30 p m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home & in Institution

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Tests

(Signed) Benj. Weisenhouse, M. D.

, 19 (Address) 320 N Chas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Cemetery	10-24 1929

20 UNDERTAKER Jack Lewis ADDRESS 1432 E Balto

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50365 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50365

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N. Carlton St., 18-1674 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gillis

(a) RESIDENCE NO. 511 N. Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced (or) WIFE of Lee Gillis

6 DATE OF BIRTH (month, day, and year) 8-10-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher (music)

(b) General nature of indnstry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Isaac Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Amanda Hunter

(Address) 511 N. Carlton

15 Filed ..., 19... [illegible] JONES, M. D. Registrar

T 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-1929

17

I HEREBY CERTIFY, That I attended deceased from 10-19-, 1929, to 10-22-, 1929, that I last saw h[illegible] alive on 10-22-, 1929, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) George C Page M. D.

, 19 (Address) 1516 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Dam	Oct 25 1929
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1105 Madison

CAUSE OF DEATH must be plainly written, and all questions answered if possible. See instructions on back of certificates.

TION is very important

Cor.—12-9-25—A Co.—200 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50366

CERTIFICATE OF DEATH.

51 E 50366

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Graziano

(a) RESIDENCE NO. 1935 Penna. Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 25, 1927

7 AGE — Years: 2 — Months: 11 — Days: 27 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Mariano Graziano

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rose Dill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Mariano Graziano

(Address): 1935 Penna. Ave.

15 Filed ..... 19 HAMILTON JONES, M. D. Registrar

DEC 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever

Myocardial Failure

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) D. K. Cullen M. D.

(Coroner)

10/25/29 18 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Woods. Date of Burial: Oct 25, 1929

20 UNDERTAKER: Martin Dakey & Sons ADDRESS: 1827 N. North Ave

Very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50367

CERTIFICATE OF DEATH

90

E 50367

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 4-7 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Coley

(a) RESIDENCE NO. 222 St. Paul ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Roy Coley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed CT 24 1929 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1929 to Oct. 21, 1929

that I last saw him alive on Oct. 21, 1929

and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute ?
(Rheumatic Origin ?)

(duration) yrs. 18 mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Aut. P.C. Lab. Autopsy

(Signed) Marvin M. McLean, M. D.

10-23, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	10-24 1929

20 UNDERTAKER ADDRESS

Byson & Wright 1218 McElderry St

Cor.—10-10-29—A Co.—100 Bks.

E 50368

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 50368

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1424 Silver Ct St., 5-9 Ward)

2-FULL NAME Joseph Jenkins

(a) RESIDENCE NO. 1424 Silver Ct St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
about 55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Police Record
(Address)

Filed OCT 24 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probable Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr. Fine 120 N. Ads-quilta

(Signed) J. S. Hines, M. D.

10/21/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Oct 24-29
20 UNDERTAKER	ADDRESS
Wendell J. Hoppe	301 S. Edenst.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50369 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 E 50369

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE, (No. 467 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME (Alexander) Aleck Carr

(a) RESIDENCE NO. 160 N. Gay St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Married~~ Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER (Alexander) Aleck Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 10-24-1929 C. HAMPSON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1929 to Oct. 22, 1929.

that I last saw h. im alive on Oct. 22, 1929

and that death occurred, on the date stated above, at 8:40 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Fascute

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. & Lab Autopsy

(Signed) Marvin M. McLean, M. D.

10-24-1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	Oct. 25 1929
20 UNDERTAKER Lilly & Gaither Inc.	ADDRESS 4038 Wolfe St

Spec.—2-29-28—L. F. S.—500 Bks.

Conrad Ball.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50370

CERTIFICATE OF DEATH

129 E 50370

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4517 Eastern ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Ball

(a) RESIDENCE NO. 4517 Eastern ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Lillian Ball.

6 DATE OF BIRTH (month, day, and year) April 14 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Lexington Market

(c) Name of employer Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Conrad Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma K. Margaardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Frank Bennett

(Address) 19 Eastern Ave

Filed OCT 24 1928, 19 HAMPSON JAMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1928

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1928, to Oct 22, 1928, that I last saw h alive on Oct 21, 1928, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Francis P. Watson, M. D.

(Address) 715 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 24 1928
20 UNDERTAKER City Funeral Home.	ADDRESS 409 E. Lexington St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

2250374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 50371

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 15-60 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abraham Mansbach

(a) RESIDENCE NO. 2219 Mondawmin ST. ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-20-69

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Levi Mansbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 FILED OCT 24 1929 WM. R. JAMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/9, 1929, to 10/24, 1929

that I last saw h[illegible]ive on 10/24, 1929

and that death occurred, on the date stated above, at 1:25 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (Urinary)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) 0 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 8/6/29

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) H. C. Smith M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sinai Hebrew Cem.	Oct 26 1929
20 UNDERTAKER	ADDRESS
David Sondheim	115 So. W. St. Bayard Cem

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50372

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 535 Hanover ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Boerne

(a) RESIDENCE NO. 535 Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 50 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Holly

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Sarah Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Sarah Holly

(Address) 535 Hanover

15 Filed 2 4 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/23/29

17 I HEREBY CERTIFY, That I attended deceased from 10/10/29, to 10/23/29, that I last saw her alive on 10/23/29, and that death occurred, on the date stated above, at 9 a.m./p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) — mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Davis, M. D.

(Address) 1727 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 10-24-1929

20 UNDERTAKER: Bennett Carton — ADDRESS: Balto

Important. See instructions on back of certificates.

Srec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50373

CERTIFICATE OF DEATH.

44 E 50373

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1321 Sargeant St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wavid Robertson

(a) Residence No. 1321 Sargeant St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Robertson

6-DATE OF BIRTH (month, day and year) Nov. 2, 1855

7-AGE. 73 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Salesman of

(b) General nature of industry, business, or establishment in which employed (or employer): fire wood

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Jesse Robertson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Caroline Robertson (don't want Maiden name)

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

14- (Informant) Sarah A. Robertson

(Address) 1321 Sargeant St

15- Filed ... 192 ... WILLIAM H. JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Oct. 22, 1929.

17- I HEREBY CERTIFY, That I attended deceased from July 29, 1929 to Oct 22 1929.

that I last saw h. alive on Oct 22 1929.

and that death occurred, on the date stated above, at 12.55 p. m.

The CAUSE OF DEATH* was as follows:

enlargent of liver, probably cirrhosis or carcinoma (most likely carcinoma)

(Duration) ... yrs. 6 mos. ... ds

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) ... yrs. 3 mos. ... ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests.

(Signed) George A. Kupp M. D.

10/23, 1929 (Address) 3030 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Oct. 25, 1929
20-UNDERTAKER. Joseph Cook	ADDRESS 1003 West Baltimore, Md.

OCT 24 1929

instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50374 — CERTIFICATE OF DEATH — 90 — E 50374

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1018 N. Eden ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Clarke

(a) RESIDENCE NO. 1018 N. Eden ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 77 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Lawrence Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Margaret Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Margaret Thorpe
(Address) 1018 N. Eden St

15 Filed: 24 1929 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-22, 1929, to 10-23, 1929, that I last saw him alive on 10/22, 1929, and that death occurred, on the date stated above, at 8 AM m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Hemiplegia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Frame M. D.

10/24/29 (Address) 6939 ½ Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Oct 25, 1929

20 UNDERTAKER: Robt L Turner — ADDRESS 1442 N Broadway

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Gilles

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50375

101-001

CERTIFICATE OF DEATH

E 50375

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 603 Amity ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Gilles

(a) RESIDENCE NO. 603 Amity ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 46 mos. ds. How long in U. S., If foreign birth 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Gilles (Deceased)

6 DATE OF BIRTH (month, day, and year) Oct 12 - 183

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	46 yr		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Kennard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Hill

(Address) 603 Amity St

15 Filed C. RAMSAY JONES, M. D. Registrar

CT 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1929, to Oct 22, 1929, that I last saw her alive on Oct 22, 1929 and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia, Lobar

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Ac Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) Charles N. Fowler, M. D.

Oct 25 1929 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Oct. 25 1929
20 UNDERTAKER	ADDRESS
I. A. Brown & Son	108 N. Monroe

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50376

CERTIFICATE OF DEATH

90 ✓ E 50376

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George McKenzie

(a) RESIDENCE NO. 915 Hillen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

003

9 BIRTHPLACE (city or town) (State or country): Alabama

PARENTS

10 NAME OF FATHER: Daniel McKenzie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alabama

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed OCT 24 1929, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 19 29, to Oct. 19, 19 29, that I last saw him alive on Oct. 19, 19 29 and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Diffuse

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Hypertension: ?

(over)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Marvin M McLean, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS OCT 24 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50377

CERTIFICATE OF DEATH

17 5 ✓ E 50377

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3413 Copley Road ST. 15-62 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn H. Hamilton

(a) RESIDENCE NO. 3413 Copley Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. P. Hamilton

6 DATE OF BIRTH (month, day, and year) March 7, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or.. min.
	73	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Worley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Anna H. Wood

(Address) 3413 Copley Road

15 [illegible] 19 C. HAMPSON JONES, M. Registrar

OCT 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23d 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1929, to Oct 23d 1929, that I last saw h[illegible] alive on Oct 23d 1929, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Gradual system degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard C Jones, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenwood Cemetery, Brooklyn, N. Y.	Oct. 25, 19 29
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons,	1900 Eutaw Pl.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓ E 50378

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 N. Chester St. ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie K. Rasch

(a) RESIDENCE NO. 1904 N. Chester St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Rasch

6 DATE OF BIRTH (month, day, and year) Oct. 9, 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Eckenrode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E. John Rasch

(Address) 1904 N. Chester St.

15 Filed 10 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1929 to Oct 22, 1929, that I last saw h[illegible] alive on October 22, 1929 and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arteriosclerosis
Chronic Interstitial Nephritis
(duration) 1 yrs. 6 mos. da.

CONTRIBUTORY (Secondary)
Cystitis
(duration) yrs mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Oct. 11 1929
20 UNDERTAKER Harry V. Witzke,	ADDRESS 1531 W. Lombard St.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50379

CERTIFICATE OF DEATH

32 E 50379

1-PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 862 Pierce St. 26 Ward)

2-FULL NAME Obirn W. Lyles (Jr)

(a) RESIDENCE NO. 862 Pierce St., _____ Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29- 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	4	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) _____
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Obirn W Lyles

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Md

12 MAIDEN NAME OF MOTHER Blanch Carmichael

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Md

14 Informant Mrs. B. Lyles
(Address) 862 Pierce St

15 _____ 19 _____ O. HAMPSON JONES, M. D. Registrar

24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Tuberculous Meningitis

(duration) yrs. 3 mos. _____ ds.

CONTRIBUTORY _____
(Secondary)

(duration) yrs. _____ mos. _____ ds.

18 Where was disease contracted If not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Eugene Gilbert M. D.

10/23. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10-24 1929
20 UNDERTAKER Daniel Easter	ADDRESS 916 Pine

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 101-001 E 50380

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 924 Harlem St. 16-23 Ward)

2-FULL NAME Trace E. Totan.

(a) RESIDENCE NO. 924 Harlem St., Ward Charlotte Hall Md.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race col

5 Single, Married, Widowed or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Totan

6 DATE OF BIRTH (month, day and year) Sept 5-1887

7 AGE Years 42 Months 1 Days 17 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Richard Sparks

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Virginia Meadows

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Robt W. Totan

(Address) 924 Harlem St

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

2 4 1929

Bur. LRB

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 22 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugenia Hallam, M. D.

Oct. 22 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saint Charles Hall Cem Maryland — DATE OF BURIAL Oct 25 1929

20 UNDERTAKER Wm M. Chase & Son — ADDRESS 1400 Myrtle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50381

CERTIFICATE OF DEATH

37-007
37E 50381

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Channel (Chesapeake Bay) on board St., 4-6 Ward)

2-FULL NAME Conrad Klasen

(a) RESIDENCE NO. Steamship Verna St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 1872

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
56	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Marine Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Verna Steamship
(c) Name of employer 030

9 BIRTHPLACE (city or town)
(State or country) Norway

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Charles C. Schroeder
(Address) 9 South St

15 Filed OCT 24 1929 C. HAMPSON JONES, M. D., Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 - 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractures and other injuries caused by being struck by piston on steamship Verna accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) sudden

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. T. Riley M.D. Coroner

Oct, 1929 (Address) 1627 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Oct 25 1929

20 UNDERTAKER George W. Zirkes — ADDRESS 1777 Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50382

CERTIFICATE OF DEATH.

129

E 50382

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 Furrow. St. 20-69 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nanetta Teufel

(a) RESIDENCE NO. 221 Furrow ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lambert Teufel

6 DATE OF BIRTH (month, day, and year) Mar 6. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ..... do

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Germany
(State or country)

PARENTS

10 NAME OF FATHER Wilhelm Kispert

11 BIRTHPLACE OF FATHER (city or town) ..... Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... Germany.
(State or country)

14 Informant Lena E. Breitenacher
(Address) 221 Furrow St.

15 2 4 1929 C. HAMPSON JONES, M. D. Registrar
Date

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept-26, 19 29, to Oct 22, 19 29, that I last saw h~ alive on Oct 22, 19 29, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma

CONTRIBUTORY (Secondary) (duration) Chronic Nephritis yrs. mos. 3 M. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Bromberg M. D.

10/28/29 (Address) 1729 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Oct 25 1929.

20 UNDERTAKER Mrs. Mrs. John W. Teufel & Son — ADDRESS 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50383

CERTIFICATE OF DEATH

74-2 50383

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leon Chambra

(a) RESIDENCE NO. 1029 Druid Hill St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora L.

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer) 0 0
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Albert S. Chambra

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Holmes

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Clarence Chambra
(Address) 202 McCulloh St

15 Filed 2 4 1929 19 C. HAMPSON JONES, M. D.
Registrar
By A Pell

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy.)
(duration) yrs. 3 hrs

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Was an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Oct 23rd 1929 Fletcher, M. D.
(Address) Garrett

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	10/25/1929
20 UNDERTAKER	ADDRESS
Mrs. Geo. H. Collard	1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

1301 St Paul

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50384

CERTIFICATE OF DEATH

38 VE 50384

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2001 Park Ave ST. 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Haberlein

(a) RESIDENCE NO. 2001 Park Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip

6 DATE OF BIRTH (month, day, and year) Aug 23 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y. City

PARENTS

10 NAME OF FATHER Ferdenand Detchel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Zerbick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Haberlein

(Address) 2001 Park Ave

15 Filed 2 4 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 29

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1929, to Oct 23, 1929, that I last saw h[illegible] alive on Oct 23, 1929 and that death occurred, on the date stated above, at 1 30 a. m.

The CAUSE OF DEATH* was as follows:

Internal Haemorrhage

CONTRIBUTORY (Secondary) Aortic Aneurism (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. E. McEuen, M. D.

Oct 24, 1929 (Address) 1301 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York N. Y.	10/25 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Parker 1114 Hartford Ave

E 50385

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50385

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH

REGISTERED NO. 10-14

CITY OF BALTIMORE: (No. 514 E. Eager ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecelia Mc Adams

(a) RESIDENCE NO. 1112 Greenmount Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Peter Mc Adams

6 DATE OF BIRTH (month, day, and year) May 29th 1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Donohue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Francis Tyding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Joseph L Mc Adams

(Address) 1112 Greenmount Ave

15 Filed OCT 4 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 1929 to Oct 24 1929

that I last saw her alive on Oct 24 1929

and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. 6 mos. (?) ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis - Physical signs

(Signed) L. Mc Cohen, M. D.

Oct 27, 1929 (Address) 111 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct 28th 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-08 E 50386

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1135 Hanover ST. 7331 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Murray

(a) RESIDENCE NO. 1135 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in whirh employed (or employer): Chauffeur

(c) Name of employer: Police Dept.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Thomas Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Louis J. Murray

(Address) 1135 Hanover St

15 Filed 2 4 1929 C. HAMPSON JONES, M. D. Registrar

Important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 22nd 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 12th, 1929, to Oct 22nd, 1929, that I last saw him alive on Oct 21st, 1929 and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Tommy Wilbert M. D.

Oct 24. 1929 (Address) 224-26 Hanover St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/25/29
20 UNDERTAKER	ADDRESS
Margaret J. Flynn	1422 Light St.

Cor.—10-10-29—A Co.—100 Bks.

William Bowman

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 50387

CERTIFICATE OF DEATH

E 50387

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 211 N. Ann St., 6-9 Ward)

2-FULL NAME Wil iam Bowman

(a) RESIDENCE NO. 211 N. Ann St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 9 mos. 1 ds. / (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Queenetta Bowman

6 DATE OF BIRTH (month, day, and year) Jan 20/1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35	9	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Autotruck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Contr
(c) Name of employer Vonderhei Coal Co

9 BIRTHPLACE (city or town) .....
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Albert Bowman

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Louden Co Va.

12 MAIDEN NAME OF MOTHER Mildred Carroll

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Alexandria, Va.

14 Informant Queenetta Bowman
(Address) 211 N. Ann St

15 Filed ....., 19.. C. HAMPSON JONES, M. D.
Registrar
Per .....

10 25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Probably Lober Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? History given

(Signed) J. H. Owen, M. D.

10/23/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cemetery	Oct. 25 1929

20 UNDERTAKER	ADDRESS
Milton Davis	413 N Eden St

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-29-29—L. F. S.—500 Blks.

E 50388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 50388

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 21-55 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William G. Speed

(a) RESIDENCE NO. 4704 Roland Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Speed

6 DATE OF BIRTH (month, day, and year) 11/20/65

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Bldg Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Managing Agt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Christopher Speed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Mary E Magers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 25 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-23-1929

17

I HEREBY CERTIFY, That I attended deceased from Oct-10, 1929, to Oct-23, 1929

that I last saw him alive on Oct-23, 1929

and that death occurred, on the date stated above, at 9:05 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Randolph Jones Jr. M. D.

. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Oct. 25 1929
UNDERTAKER Wm J Pickerstone	ADDRESS N. Y. Ave

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

50389 — 50389

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard G. Anderson

(a) RESIDENCE NO. 611 Garrett Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Anderson

6 DATE OF BIRTH (month, day, and year) Nov 17-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	56	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman $6 0

(b) General nature of industry, business, or establishment in which employed (or employer) W. S. Levy Co

(c) Name of employer

9 BIRTHPLACE (city or town) Odenton

(State or country) Md.

PARENTS

10 NAME OF FATHER Edward E. Anderson

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Virginia Spear

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Hospital Record

(Address)

15 Filed OCT 25 1929, 19.. J. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 1929, to 10-24, 1929,

that I last saw h alive on 10-24-29, 19..,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer causing pyloric obstruction

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-24-29

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Robert Wells, M. D.

(Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL Oct. 26, 1929

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS Mt. Pleasant

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50390

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... St. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Johnson

(a) RESIDENCE NO. Magothy River. ST., Arnold States WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed

3a If married, widowed or divorced
~~HUSBAND~~ of
(or) WIFE of Wm. H. Johnson

6 DATE OF BIRTH (month, day, and year) Oct 6 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~65~~	66	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Magothy River~~ Green Spring Valley Va.

PARENTS

10 NAME OF FATHER Chas. Bohle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records
(Address)

15 Filed OCT 25 1929 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/23 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/22 1929 to 10/23 1929.

that I last saw her alive on 10/23 1929,

and that death occurred, on the date stated above, at 6 05 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) unk yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 10/22/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) C. H. Hampson Jones M. D.

(Address) 1729 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Bros	Oct 27 1929
20 UNDERTAKER Wm. Pickenbrock	ADDRESS N. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50391 — E 50391

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO. 90

CITY OF BALTIMORE: (No. ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Kinnier

(a) RESIDENCE NO. 1120 Division St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth?— yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Kinnier

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Lewis

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed 12 26 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-29

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 1929, to 10-22, 1929, that I last saw him alive on 10-22, 1929 and that death occurred, on the date stated above, at 12-30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Diffuse

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma Chronic Diffuse

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.C. Lab. X-ray

(Signed) Warren H. McLean, M. D.

10-22, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	10 25 1929
20 UNDERTAKER	ADDRESS
Frank J. Kunkel	578 N. Eddel St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 50392

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50392

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427-W-23 ST., 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Elizabeth Frock.

(a) RESIDENCE NO. 427-W-23 ST., 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Frock

6 DATE OF BIRTH (month, day, and year) Nov 14, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Fellows

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant William Frock (Address) 427-W-23rd St.

15 Filed ... 19 ... Registrar

CT 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1929, to Oct 22, 1929, that I last saw her alive on Oct 22, 1929, and that death occurred, on the date stated above, at 4.03 PM

The CAUSE OF DEATH* was as follows:

Para-hypertension Beta

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Uremic convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Murray Levin M. D.

10-22-1929 (Address) 2438 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Oct 25 1929

20 UNDERTAKER Wm Cook 1207 — ADDRESS St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50393 — CERTIFICATE OF DEATH — E 50393

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 12-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr Clarence E Williamson

(a) RESIDENCE NO. 104 Polo Drive ST., atlanta ga WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) Sept 29, 1874

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55 years		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lexington Ky.

PARENTS

10 NAME OF FATHER Charles P Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Betty Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Hospital Records

(Address)

15 Filed OCT 25 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929, to Oct 24, 1929, that I last saw him alive on Oct 24, 1929, and that death occurred, on the date stated above, at 6⁴⁰ P.m.

The CAUSE OF DEATH* was as follows: Carcinoma of colon

Peritonitis with ascending Pulmonary Edema following operation

(duration) ? yrs. 7 mos. 3 ds.

CONTRIBUTORY ~~Carcinoma colon~~ (Secondary) Peritonitis (duration) yrs. 2 mos. 3 ds.

18 Where was disease contracted if not at place of death? atlanta & Baltimore

Did an operation precede death? yes Date of 10/21/29

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) T. C. Thompson M. D.

10/24, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Atlanta Ga	Oct 26th 1929
20 UNDERTAKER	**ADDRESS**
Wm Cook	127 St Paul St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50394

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50394

1—PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver Sts 25-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Anna Pawlaszak

(a) RESIDENCE NO. 1610 Ceral St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Martin Pawlaszek

6 DATE OF BIRTH (month, day, and year) ~~[illegible]~~ Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Damazyn Cidzikowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Kowalzyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Helena Szafranek

(Address) 1612 Hazel St

15 Filed ..... 19.. C. ... GIBSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23-29

17 I HEREBY CERTIFY, That I attended deceased from 9-29, 1929, to 10-23, 1929.

that I last saw h.. alive on 10-23, 1929

and that death occurred, on the date stated above, at 12 02 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colecystitis Chronic

(duration) about 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 10-1-29 Removal gall bladder

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Clinical

(Signed) M. Kwiecinski, M. D.

(Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	10/26 1929
UNDERTAKER	ADDRESS
J. Fialkowski	1618 Eastern

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

50395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 E 50395

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 7-69 WARD)

2-FULL NAME Thomas Lorenz

(a) RESIDENCE No. 12 S. Pulaski ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 21 - 1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
—	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Paul Lorenz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine Whelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs Lorenz

(Address) 12 S Pulaski St

15 Filed Oct 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1929, to Oct 24, 1929, that I last saw him alive on Oct 24, 1929, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. B. Peters M. D.

Oct 26 1929 (Address) 207 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 26 1929
20 UNDERTAKER George L. Schwab	ADDRESS 2101 Eutaw Pl

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50396

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50396

CERTIFICATE OF DEATH

123

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 432 N. Highland Ave ST., 16-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma A. Hartmann

(a) RESIDENCE NO. 432 N. Highland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of: Louis Hartmann

6 DATE OF BIRTH (month, day, and year): Apr 12 1863

7 AGE: Years 67 Months 6 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Francis Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Louis Hartmann

(Address) 432 N. Highland

15 Filed OCT 25 1929 19 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24 29

17 I HEREBY CERTIFY, That I attended deceased (from ..... 19..., to ..... 19...) that I last saw h alive on Oct 24 19 29 and that death occurred, on the date stated above, at 7:45 A. M.

The CAUSE OF DEATH* was as follows:

Gall stones — Cholecystitis, Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Todd Duncan M. D.

10-24-29 19 (Address) 800 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: Oct 26 19 29

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Arlington Ave

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

50397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 50397

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. #620 N. Lakewood Ave St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Wick

(a) RESIDENCE NO. #620 N. Lakewood Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of late Herman Wick

6 DATE OF BIRTH (month, day, and year)
Nov. 25th. 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) City

PARENTS

10 NAME OF FATHER Conrad Kaufman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germeny

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Frank Wick
(Address) 620 N. Lakewood Av

15 Filed C. HARRISON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins (Coroner) M. D.

10/24/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem. Date of Burial Oct 26. 29

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50398

CERTIFICATE OF DEATH

44 E 50398

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 E. Fayette ST. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony A. Schirmer

(a) RESIDENCE NO. 2304 E. Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Anna C. Schirmer

6 DATE OF BIRTH (month, day, and year): Mar 20 1874

7 AGE — Years: 55 — Months: 7 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna C. Schirmer

(Address): 2304 E. Fayette St.

15 Filed ..... 19 ..... C. HAWSON Jones, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 23/24

17 I HEREBY CERTIFY, That I attended deceased from Apl 18 . 19 24 . to Oct 23 . 19 24 . that I last saw h[illegible] alive on Oct 22 24 and that death occurred, on the date stated above, at 9-15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Intestines

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic absorption

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of At Mercy Hospital

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward [illegible], M. D.

10/24 19 24 (Address) 413 E. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Oct 26 1924

20 UNDERTAKER: Philip Herring — ADDRESS 206 Aisquith St

Important. See instructions on back of certificates.

OCT 25 1924

Spec.—2-29-28—L. F. S.—500 Bks.

E 50399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50399

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 North Monroe ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Hogan

(a) RESIDENCE NO. 515 North Monroe ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Hogan

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocery Business

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Patrick Hogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Custy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Hogan

(Address) 515 N. Monroe St.

15 Filed OCT 25 1929, 19 Dep. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929 to Oct. 24, 1929

that I last saw him alive on Oct. 24, 1929

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 5 Yrs.

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Cronkhite M. D.

, 19 (Address) 24 N Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/26 1929
20 UNDERTAKER Chas P. Evans & Son	ADDRESS Mt Royal Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50400

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50400

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 90-27

CITY OF BALTIMORE: (No. 1941 Loretta Ave ST., (.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Lee

(a) RESIDENCE NO. 1941 Loretta Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Abt. 30 yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Negro	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Lee

6 DATE OF BIRTH (month, day, and year) Oct. 15th. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 10 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) Fredrick, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Isaac Dandrige (Son inLaw)

(Address) 1941 Lauretta Ave

15 FILED OCT 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-22-'29

17 I HEREBY CERTIFY, That I attended deceased from Oct.17th.1929 to Oct. 22nd. 1929.

that I last saw her alive on Oct 22nd.1929

and that death occurred, on the date stated above, at 6;30p. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) 2 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J.Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	10/25/29
20 UNDERTAKER Mrs. P. A. Elliott	ADDRESS 1725 Ashland

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 29 9 09
E 29 0401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113

E 50401

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2-4 WARD)

2—FULL NAME Felix Andreasik

(a) RESIDENCE NO. 125 S. Linham ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-2-28

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Felix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Louise Olszewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

C. HAMILTON JONES, M. D. Registrar

OCT 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-23-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Oct 23, 1929

that I last saw him alive on Oct 23, 1929

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis

(duration) yrs. 6 wks. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. V. Bickford, M. D.

10/23, 1929 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Oct 25 1929
20 UNDERTAKER	ADDRESS
George A. Weber	705 Lanvale

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50402

CERTIFICATE OF DEATH

161-001 E 50402

REGISTERED NO.

1—PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Linsbard & Green ST. 19-28 WARD)

2—FULL NAME Baby girl Stevens

(a) RESIDENCE NO. 1814 Wichelm ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Corless Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Corless Stevens

(Address) 1814 Wichelm St.

15 Filed , 19 H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929 to Oct 24, 1929

that I last saw her alive on Oct 24, 1929

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Premature baby

marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. B. Johnson, M. D.

Oct 24, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Oct. 25 1929

20 UNDERTAKER Harry W. Dietzel

ADDRESS 531 W. Lombard

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50403 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50403

CERTIFICATE OF DEATH

117

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Calhoun ST., 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry E. Ault Sr

(a) RESIDENCE NO. 3338 Gilmore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Ault

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	56		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Ault

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elenora Smoot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Minnie E. Ault

(Address) 333 E. Gilmor Ste.

15 Filed OCT 25 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1929, to Oct 23, 1929, that I last saw him alive on Oct 23, 1929 and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendiceal abscess

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Oct. 22 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M B Schreiber, M. D.

Oct 23, 1929 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct. 26, 1929
20 UNDERTAKER Harry V. Wittke 1331 W. Lombard St.	ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50404 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

100-001 E 50404

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1625 E. Lombard ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine Klingelhofer

(a) RESIDENCE NO. 1625 E. Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 15 ds. How long in U. S., if foreign birth? 7 yrs. 7 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15, 1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Min.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Klingelhofer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katharyn Krill

13 BIRTHPLACE OF MOTHER (city or town) Providence
(State or country) R. I.

14 Informant William Klingelhofer
(Address) 1625 E. Lombard

15 Filed OCT 25 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-25-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct-21, 1929, to Oct-25, 1929, that I last saw h[illegible] alive on Oct 24, 1929 and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) John D. Wade, M. D.

19 (Address) 118 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carm[illegible] St. Matthews	Oct 26 1929
20 UNDERTAKER Louis Heuman	ADDRESS 33 S. Broadway

Important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50405

CERTIFICATE OF DEATH

159-002

REGISTERED NO. E 50405

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 Loudon Ave. ST. 20-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Joseph Fitzsimmons

(a) RESIDENCE NO. 247 Loudon Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James F. Fitzsimmons

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Edith V. Burkman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mr. James F. Fitzsimmons
(Address) 247 Loudon Ave.

15 Filed OCT 25 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 24, 1929, that I last saw h alive on Oct 24, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/25, 1929 (Address) 1729 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Oct. 25, 1929
20 UNDERTAKER Harry V. Dwitzki 5-31	ADDRESS Lombard St.

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50406

CERTIFICATE OF DEATH.

90 E 50406

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1724 Ellamont St. 15-62 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Francis Thompson

(a) RESIDENCE NO. 1724 Ellamont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgette V. Thompson

6 DATE OF BIRTH (month, day, and year) May 4-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portsmouth England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Georgette V. Thompson (Address) 1724 Ellamont St.

15 Filed OCT 29 1929 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23rd 1929

17

I HEREBY CERTIFY, That I attended deceased from March, 1929, to Oct 23, 1929, that I last saw him alive on Oct 23, 1929, and that death occurred, on the date stated above, at 7.50 m.

The CAUSE OF DEATH* was as follows:

Uremia Edema

Chronic Endocarditis

Chronic Rheumatism (Articular)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophied Heart

(duration) yrs. mos. 8 hours

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) [illegible], M. D.

10/24, 1929 (Address) 3279 Harwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Oct 26 1929

20 UNDERTAKER Bertram & Son — ADDRESS 1723 W. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50407 — 87 — E 50407

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1915 (St.) Harlem Ave (Ward) 20-28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Moore

(a) RESIDENCE NO. 1915 (St.) Harlem Ave (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Latchford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Katey Moore

(Address) 1915 Harlem Ave

15 Filed OCT 25 1929 C. HAMPSON JONES, M. D. Registrar

Per ———

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1929 to Oct 23 1929.

that I last saw him alive on Oct 22 1929.

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(duration) yrs. 1 mos 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

10/24 1929 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 10/30 1929

20 UNDERTAKER Geo A Farley

ADDRESS Govans Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50408

CERTIFICATE OF DEATH

X 188-293

E 50408

1-PLACE OF DEATH

City of Baltimore: (No. W. Balto Gen Hosp 16-68 St. ..... Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Wilhelm

(a) RESIDENCE NO. Parkton Md St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May-23-1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26	5	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist 031
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Compton & Sons

9 BIRTHPLACE (city or town) Mt Carmel Balto Co
(State or country)

PARENTS

10 NAME OF FATHER David Wilhelm

11 BIRTHPLACE OF FATHER (city or town) Balto Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida M. Hamsher

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co Md
(State or country)

14 Informant David Wilhelm, (Address) Parkton, Md.

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

12 5 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fract Femur
Auto in which he was riding collided with another

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupt. Bladder

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sparks Md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. J. Frame M. D.

10/25 1929 (Address) 29 39th St Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forestes, Md.	Oct 27 1929
20 UNDERTAKER	ADDRESS
Wm. C. Brooks & Son	Sparks, Md

tion should be carefully supplied. AGE should be stated OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E. 50409

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 50409

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3036 Phila Ave. ST. 6-11 WARD)

2—FULL NAME Samuel James Fowler

(a) RESIDENCE NO. 3036 Phila. Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Georgia Fowler

6 DATE OF BIRTH (month, day, and year) Mch. 6, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer on Boat

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 30

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Alice Horn

(Address) Easton on Essex

15 Filed 25 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24/29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1929, to Oct. 24, 1929.

that I last saw h— alive on Oct. 24, 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis
Myocarditis
Nephritis

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Artigiani, M. D.

, 19 (Address) 294 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct. 26 1929
20 UNDERTAKER John G. Connelly	ADDRESS Essex Md

important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 50410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 50410

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 591, Burgess Ave. St.; 27-43 WARD)

2-FULL NAME Rudenda W. Von Behren

(a) RESIDENCE. No. 591 Burgess Ave St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Von Behren

6 DATE OF BIRTH (month, day, and year) April 8, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gustav Von Behren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas Von Behren
(Address) 591 Burgess Ave

15 Filed OCT 25 1929 C. HAMPSON JONES, M. D. Registrar

By AKW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 1929 to 10/24 1929, that I last saw h— alive on 10/24 1929 and that death occurred, on the date stated above, at 2a, m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerosis, Chronic Interstitial Nephritis, Hypertension Aneurysm Aortic.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Tyler W. Foley, M. D.

, 19 (Address) 5703 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	10/26/29

20 UNDERTAKER Geo Leimbach & Son ADDRESS 528 N Lyndhurst St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 50411

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1609 Bolton Street 44-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy B. Cotten

(a) RESIDENCE NO. 1609 Bolton St., ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of W. Augustus Cotten

6 DATE OF BIRTH (month, day, and year) Aug. 14, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Plymouth, N. C.

PARENTS

10 NAME OF FATHER John M. Boyle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Plumb

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14

Informant Mrs. Louise C. Stirling

(Address) 1609 Bolton St.

15

FILED 10 25 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to Oct 24th, 1929,

that I last saw h alive on Oct 24th, 1929,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cancer of liver and hepatic ducts of Colon

(duration) — yrs. 10 mos. — ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) E. L. Van Metre, M. D.

10 25, 1929 (Address) 1515 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Oct. 26/29 19
20 UNDERTAKER	ADDRESS
Thornton & Son	Fort Wayne Ind.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

230390 50412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH X 100-001 E 50412

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John G. Harrison

(a) RESIDENCE NO. Tilghman - Mal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Charles Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Mary Busemyland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 HAMPSON JONES, M. D., Registrar

OCT 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 29

17 I HEREBY CERTIFY, That I attended deceased from October 22. 1929. to October 25. 1929.

that I last saw him alive on October 25 . 1929

and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Bilateral bronchopneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. T. Bickford Jr. M. D.

.19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lebanon Cem. Balto Md.	Oct 27 1929
20 UNDERTAKER W E Lees Sons	ADDRESS 5421 Harford Ave

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50413

CERTIFICATE OF DEATH.

101-601

E 50413

1-PLACE OF DEATH

City of BALTIMORE: (No. 1435 Jefferson St. 5-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Carrol

(a) RESIDENCE NO. 1435 Jefferson St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9-1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Charles Carroll

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Hester Cooper

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Hester Carroll

(Address) 117 N. Dallas St.

15 Filed OCT 26 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above. 3 P.M.

The CAUSE OF DEATH* was as follows: Probably Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Collins M. D.

(Coroner)

10-25/29 (Address) 500 E. [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Date of Burial Oct. 28 1929

20 UNDERTAKER Chas. R. Johnson ADDRESS 1756 N. Caroline St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 50414

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 Calvert Ave ST. 20-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie S Hood

(a) RESIDENCE NO. 601 Calvert Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 22-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Sherman Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Isabell Mahwarth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) USA

14 Informant Sherman Hood

(Address) 3526 Clipper Road

15 Filed OCT 26 1929 19 HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25-1929

17 I HEREBY CERTIFY, That I attended deceased from 10-22, 1929 to 10-25, 1929

that I last saw h alive on 10-24, 1929

and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows: Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenny, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Perora Balto Co	Oct 26 1929
20 UNDERTAKER Wm J Tessmer Sons	ADDRESS North Av

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50415

E 50415

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Enroute St. Josephs Hospital St. 2-4 Ward)

2-FULL NAME Antoni K. Szamski

(a) RESIDENCE NO. 2031 Eastern Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 1924

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ... min.
5	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Antoni P. Szamski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER
Mary Brzozowski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Antoni P. Szamski
(Address) 2031 Eastern Ave.

15 Filed ... 19... C. HUMPSON JONES, M. D. Registrar

26 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Tonsilitis -Lagri pa

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 10-26/29 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Oct. 28	19 29
20 UNDERTAKER	ADDRESS
F. W. Ozazewski 1939	Eastern

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Bks.

E 50416

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 ✓ E 50416

CERTIFICATE OF DEATH

1—PLACE OF DEATH Cent. Bay REGISTERED NO.

CITY OF BALTIMORE: (No. 1623 Chas 25h ST. 25-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antoni Jan Koc

(a) RESIDENCE NO. 1623 Charles st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18-1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1623 Chas 25th.

PARENTS

10 NAME OF FATHER John Koc

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Stec

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Mary Koc
(Address) 1623 Chas 25th

15 Filed OCT 26 1929, 19 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1929, to Oct 25 1929, that I last saw h[illegible] alive on Oct 24 1929, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Hotka, M. D.

Oct 25 1929 (Address) 4700 Pennington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Oct 26 1929
20 UNDERTAKER	ADDRESS
H W Ozazewski	1980 Eastern Av.

T 26 1929

IF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 50417

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 4811 Harford Ave. ST. 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Stoffregen

(a) RESIDENCE NO. 4811 Harford Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Stoffregen

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles J. Stoffregen

11 BIRTHPLACE OF FATHER (city or town) Hanover
(State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Hartman

13 BIRTHPLACE OF MOTHER (city or town) Hanover
(State or country) Germany

14 Informant Mrs. Harry P. Clifton
(Address) 4811 Harford Avenue

15 Filed C. HANSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1929, to Oct. 25, 1929, that I last saw him alive on October 24, 1929 and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis due to
Cerebral Hemorrhage

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

10/26, 1929 (Signed) Benj. B. Hayden, M. D.

(Address) 1216 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian Cemetery	Oct. 26 1929
20 UNDERTAKER Joseph D. Cox	ADDRESS 1003 West Baltimore St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50418

CERTIFICATE OF DEATH. 1929

E 50418

1-PLACE OF DEATH St Agnes Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 1 ST. 25-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Edith L. Copley

(a) RESIDENCE No. Aurora Illinois ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs E. Copley

6 DATE OF BIRTH (month, day, and year) Mar 4. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
59	~~59~~ 59	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chebergan McChegan

PARENTS

10 NAME OF FATHER Wilson Strohman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Mary Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Mrs E. Copley

(Address) Aurora Illinois

15 Filed CT 26 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 10 1929 to Oct 25 1929.

that I last saw h alive on Oct 25 1929

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Post operative general infection

Streptococcus haemolyticus in blood

(duration) yrs. mos 7½ ds.

CONTRIBUTORY (Secondary) Operation - Submucous Resection Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Allegheny Hospital

Did an operation precede death? yes (Date of Oct 17, 1929

Was there an autopsy? no

What test confirmed diagnosis? Pathological Exam of Tissue

(Signed) Theodore Woodward M. D.

, 19 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aurora Illinois

DATE OF BURIAL Oct 26 1929

20 UNDERTAKER Henry H. Erkins Sons

ADDRESS McCulloh & Orchard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 50419

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4418 Roland Ave. ST. 27-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth V. Gans

(a) RESIDENCE NO. 4418 Roland Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edgar H. Gans

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary B. Nunan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant J. Edgar Gans Jr.

(Address) 4418 Roland Ave.

15 Filed OCT 26 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1929, to Oct 24, 1929

that I last saw her alive on Oct 24, 1929

and that death occurred, on the date stated above, at 3.50 P. m.

The CAUSE OF DEATH* was as follows:

Autosclerosis
Ch Ist Nephritis
Ch Myocarditis -

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. W. Bishop, M. D.

Oct 25, 1929 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Oct. 28/1929
20 UNDERTAKER	ADDRESS
Howard & Son	1054 Calvert St.

important. See instructions on back of certificates.

Spec.—2-29-28—I. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50420

185 E 50420

CERTIFICATE OF DEATH

1—PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline + Eden ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Hardy

(a) RESIDENCE NO. 1759 Elsworth ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Essie Hardy

6 DATE OF BIRTH (month, day, and year) January 18 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm. Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Essie Hardy

(Address) 1759 Elsworth St.

15 Filed OCT 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-25-29

17 I HEREBY CERTIFY, That I attended deceased from 10-9, 1929, to 10-25, 1929, that I last saw h alive on 10-25, 1929 and that death occurred, on the date stated above, at 9:25 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Fractured Skull Cerebral Laceration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical observation

(Signed) W. B. Hundley M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenlawn Va	Oct 27, 1929
20 UNDERTAKER Mrs. R. H. Ellicott	ADDRESS 1715 Eastland

Important. See instructions on back of certificates. Property classified. Last statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50421

118-002

CERTIFICATE OF DEATH

E 50421

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michaelle Jones

(a) RESIDENCE NO. 1719 W Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day and year): July 17-1906

7 AGE: Years 23 Months 3 Days 7 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) [illegible] Md.
(State or country)

PARENTS

10 NAME OF FATHER: Chas Jones

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant: Mary Jones
(Address) 1719 W. Lanvale

15 Filed OCT 26 1929 C. H. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct 24th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Retention of Urine

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Oct 24th H. Leech M. D.

(Address) Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct. 27 1929
20 UNDERTAKER: Mrs. R. G. Elliott	ADDRESS 1745 Gaithers

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50422

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 50422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hospital (6-27) St. (Ward)

2-FULL NAME Rosie Grahams

(a) RESIDENCE NO. 922 E. Lees St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Richard Graham

6 DATE OF BIRTH (month, day, and year) May 3, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	38	5	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER George J. Webster

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Pomella Upshaw.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown.

14 Informant Richard Graham
(Address) 922 E. Lees

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Nephritis-Lung Odema (Tuberculosis?)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy 5 months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ... M. D.

10/20/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedony Cemetery	Oct. 26 1929
20 UNDERTAKER Mrs. P.G. Elliott	ADDRESS 1325 Eastlund Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50423

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50423

CERTIFICATE OF DEATH

112

1-PLACE OF DEATH

City of Baltimore: (No. 508 N Presstman St., 17-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. F. Milburn

(a) RESIDENCE NO. 731 Bradley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) Aug 25-1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	1	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo F. Milburn

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Richardson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Lucy Milburn
(Address) 731 Bradley

15 Filed OCT 26 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion 6 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Error of diet 6 hours

(duration) yrs. mos.

18 Where was disease contracted If not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Oct 24th Herbert Haskins, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Oct 27, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 N. Schroeder St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50424

CERTIFICATE OF DEATH

47 E 50424

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 738 E. Biddle ST. 10-14 WARD)

2—FULL NAME Susan Englebrecht

(a) RESIDENCE NO. 728 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? —yrs. —mos. —ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

a If married, widowed, or divorced HUSBAND of (or) WIFE of George Englebrecht

6 DATE OF BIRTH (month, day, and year) 2/25/1869

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
60	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md
(State or country)

PARENTS

10 NAME OF FATHER Young

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Mrs. M. Englebrecht
(Address) 728 E. Biddle St

15 Filed OCT 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/24/29

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to Oct 24, 1929, that I last saw her alive on Oct 24, 1929, and that death occurred, on the date stated above, at 1:40 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gilbert K. Clay M. D.

10/25/29 (Address) 800 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL 10/27/1929

20 UNDERTAKER George J. Keith ADDRESS 1735 Harford

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50425

CERTIFICATE OF DEATH

E 50425

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 26-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME [redacted] Pallotta.

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Whit	Singl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Matteo Pallotta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Record

(Address)

15 Filed OCT 28 1929 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/29

17 I HEREBY CERTIFY, That I attended deceased from 1/1/29, 1929, to 10/27, 1929,

that I last saw h[illegible] alive on 10/27, 1929

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Carcinoma rectum

Tuberculosis right lung apex

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Tompkins, M. D.

10/28, 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	10/30/29
20 UNDERTAKER	ADDRESS
G. J. Ruth	35 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50426

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 702 E. 30th St. (ST.) 9-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anne A. Frazer

(a) RESIDENCE NO. 702 E. 30th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm E. Frazer

6 DATE OF BIRTH (month, day, and year) Apr 6 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Benj Gfrazer

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Mary Santmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant W. E. Frazer

(Address) 702 E Baltimore

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) October 24/29

17 I HEREBY CERTIFY That I attended deceased from Sept 24th, 1929, to Oct 24th, 1929

that I last saw her alive on Oct 24th, 1929

and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 1 ds.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo Montgomery III M. D.

10/27/29 (Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	10/28/1929
20 UNDERTAKER J. J. Moran	ADDRESS 300 E Balto.

OCT 26 1929

BALTIMORE, MD.

Pat. Co.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50427

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 50427

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1032 N Eden ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John D. Delghman

(a) RESIDENCE NO. 1032 N Eden ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah E Delghman

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Sarah E Delghman

(Address) 1032 N Eden st.

15 Filed OCT 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1929. to Oct 23. 1929.

that I last saw him alive on Oct 23. 1929

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Renile)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension and Paralysis.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Gordon M. D.

10/25. 1929 (Address) 1424 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem.	Oct. 26 1929
20 UNDERTAKER	ADDRESS
Mrs J G. Locke	1302 Jefferson

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 50428

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 12-51 WARD)

2—FULL NAME Mollie Lambert

(a) RESIDENCE NO. 2843 Huntington Ave. ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth?— yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Richard Lambert

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Adam Baner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed OCT 26 1929 C. HAMPSON JONES, Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 19 29, to Oct. 24, 19 29,

that I last saw h.er alive on Oct. 24, 19 29

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial degeneration Fatal

Bronchopneumonia (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & C. Exam

(Signed) Marion M. McLean, M. D.

10-25, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct 28 19 29
20 UNDERTAKER	ADDRESS
Chenowith Son	2007 Christmas Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50429

CERTIFICATE OF DEATH.

90 E 50429

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 - S. Sharp ST. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Ethel Simms

(a) RESIDENCE No. 1230 - S. Sharp. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Simms

6 DATE OF BIRTH (month, day, and year) 2-13-1896.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min
	33	8 —	11 —	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Newark. (State or country) N. J.

PARENTS

10 NAME OF FATHER Jonah Foreman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ida Hanna.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Ida Foreman. (Address) 1230 S. Sharp.

Filed OCT 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24-1929

17 I HEREBY CERTIFY, That I attended deceased from 10-20-, 1929, to 10-24-, 1929, that I last saw h[illegible] alive on 10-23-, 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. H. Carroll, M. D.

10-26 1929 (Address) 611 N. Carol

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL Oct 26 1929

20 UNDERTAKER Walter B. Sea[illegible]

ADDRESS 139 W. Hamburg St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Anna Rybicki

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50430

CERTIFICATE OF DEATH

75-001

E 50430

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3822 Leo St Wagners Point ST. 25-75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Rybicki

(a) RESIDENCE NO. 3822 Leo Street ST., 75 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

.a If married, widowed, or divorced WIFE (or) HUSBAND of Joseph Rybicki

6 DATE OF BIRTH (month, day, and year) Oct/15/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	-	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 037

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Jurbinski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Joseph Rybicki

(Address) 3822 Leo Street

15 Filed OCT 26 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24/29.

17

I HEREBY CERTIFY, That I attended deceased from Oct 17 1929, to Oct 24 1929.

that I last saw h[illegible] alive on Oct 23 1929

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia.
(Primary)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. S. Hoth, M. D.

Oct 25, 1929 (Address) 806-Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.A.Co. Oct/28/1929	19

20 UNDERTAKER George A. Weber ADDRESS 705 S. Ann St

Be sure all the plain items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50431

HEALTH DEPARTMENT—CITY OF BALTIMORE

65 1001 E 50431

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 28-56 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Simon

(a) RESIDENCE NO. 50 Patapsco Ave. ST. Preakness WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Follows race horses

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10 NAME OF FATHER Washington Simon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oklahoma

12 MAIDEN NAME OF MOTHER Irene ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oklahoma

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed OCT 26 1929 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1929, to Oct. 25, 1929, that I last saw h... alive on Oct. 25, 1929 and that death occurred, on the date stated above, at 4 A.M. p. m.

The CAUSE OF DEATH* was as follows:

Typhoid Septicemia, 4 days

Myocarditis, chronic ? date

(duration) 3? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typ. O. Agglutination Gaer.

(Signed) Warren H. W... M. D.

10-25, 19... (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	10/28 19 29
20 UNDERTAKER	ADDRESS
Fred'l Townsley & Son	1718 N. Eutaw

Be sure DEATH is filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50432

REGISTERED NO. 101-E 50432

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 908 Argyle St.) (Ward) 17-24

2-FULL NAME Daniel W. Richardson

(a) RESIDENCE NO. 908 Argyle St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jennie Richardson

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ins Agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Jennie Richardson
(Address) 908 Argyle Ave

15 Filed ..... 19 ....
OCT 28 1929
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Chas. Louis Leas, M. D.
Oct 28th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	10/27 1929

20 UNDERTAKER

ADDRESS

James F. Donnelly 578 N. Bond

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50433 — CERTIFICATE OF DEATH — + 160 ✓ E 50433

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE, (No.) Provident Hosp ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Sterrett

(a) RESIDENCE NO. 20 Rich Ave ST. Douglass Park WARD Catonsville

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): June 24 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Catonsville Md

PARENTS

10 NAME OF FATHER: Samuel A Sterrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Maggie Litton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Maggie Sterrett

(Address): 20 Rich Ave Catonsville

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25; 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 19 29 to Oct 25 19 29

that I last saw h[illegible] alive on Oct 25 19 29

and that death occurred, on the date stated above, at 1.05 p.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clin

(Signed) B Harris, M. D.

Oct 29 19 29 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem Balto Co	10 30 19 29
20 UNDERTAKER	**ADDRESS**
Samuel Townsley	5767 Liddle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 50434

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 N. Patterson Pk ST., 6-10 WARD)

2-FULL NAME Infant Krausman,

(a) RESIDENCE No. 221 N. Patt. Pk. St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25, 1929

7 AGE Years Months Days If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Alfred Krausman

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Myrtle Creel

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant
(Address)

15 Filed OCT 26 1929 H. LEMPSTONE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1929, to Oct. 25, 1929, that I last saw him alive on Oct. 25, 1929, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth (6 mos.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis J. Feingold M. D.

Oct. 26, 1929. (Address) 700 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS OCT 26 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Inf Wade.

HEALTH DEPARTMENT—CITY OF BALTIMORE

50435

CERTIFICATE OF DEATH

161-001

E 50435

1-PLACE OF DEATH

City of Baltimore: (No 1403 N. Fremont St 14-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Not Name.

(a) RESIDENCE NO. 1403 N. Fremont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): Oct 25-1929

7 AGE: Years | Months | Days: 1 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Howard Dorsey

11 BIRTHPLACE OF FATHER (city or town): Balto
(State or country)

12 MAIDEN NAME OF MOTHER: Jessie Wade

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country)

14 Informant: Jessie Wade
(Address) 1403 N. Fremont

15 Filed OCT 26 1929 THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry)
The CAUSE OF DEATH* was as follows:

Premature Birth
(duration) yrs. Sudden

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Oct 25 (Address) Coroner, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

OCT 26 1929

4005

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50436

CERTIFICATE OF DEATH

10-002

E 50436

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Edward Herndon

(a) RESIDENCE NO. 1620 N. Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 18, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	1	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Herndon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Coretta Jayson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Coretta Herndon

(Address) 1620 N. Gilmore St.

15 Filed OCT 26 1929 19 Lily Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929, to Oct 25, 1929, that I last saw him alive on Oct 24, 1929 and that death occurred, on the date stated above, at 1.10 a.m.

The CAUSE OF DEATH* was as follows:

Nasal, Tonsillar & Laryngeal Diphtheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Diphtheritic Myocarditis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 1620 N. Gilmore St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical Symptoms & Culture

(Signed) Addison Craft Ruby, M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md.	Oct 26 1929
20 UNDERTAKER Thomas E. Kelson.	ADDRESS 1303 Eastern St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50437

CERTIFICATE OF DEATH

58-001

E 50437

1-PLACE OF DEATH Good Shepherd Hospital REGISTERED NO. 13-59

City of BALTIMORE: (No. 1510 N. Gilmore St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Bowen

(a) RESIDENCE NO. ~~1510 Gilmore~~ 2503 Madison ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE: Years 38 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va.

14 Informant: Good Shepherd Hosp

(Address): 1510 N. Gilmore Ba

15 Filed OCT 26 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 29 to Oct. 24, 29

that I last saw her alive on Oct. 24, 29

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia ?

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 14 da.

18 Where was disease contracted? Rochester Co Va

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) S. B. Hughes M. D.

Oct 25 1929 (Address) 1413 S. Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gloucester Va — Date of Burial 10-26 1929

20 UNDERTAKER: Dennis Eanes — ADDRESS Glo Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50438

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 50438

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hosp ST. 22-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Roddy Walker

(a) RESIDENCE NO. 613 Montgomery ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7, 1903

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 040

9 BIRTHPLACE (city or town) (State or country) Chester S.C.

PARENTS

10 NAME OF FATHER Robt Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dutt Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Providence Hosp

(Address)

15 Filed ....., 19.... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24/1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1929, to Oct 24, 19 29, that I last saw him alive on Oct 24, 19 29 and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Fibrous Pleurisy

Chronic Tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

10/26, 19 29 (Address) Provident Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chester S.C.	10-26 1929
20 UNDERTAKER	ADDRESS
Davis Estate	Dr. [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S. P. C.—2-29-28—L. F. S.—500 Bks.

E 50439

E 50439

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 50439

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD) 16-1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest C Exter

(a) RESIDENCE NO. 3200 Fait ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Exter

6 DATE OF BIRTH (month, day, and year) Dec. 20th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Ex Inspector 013

(c) Name of employer P. R. R.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Charles Exter

(Address) 114 Ritchie Hill ave

15 Filed OCT 26 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25-1929

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1929, to October 25, 1929, that I last saw h living alive on October 25, 1929, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis (General)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Broncho

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms Phy. Find.

(Signed) W. Glenn Speicher M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 28 1929
20 UNDERTAKER	ADDRESS
Frederick Lasch & Sons	Fullerton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-12-23—M&T—500 Bks.

✓ E50440
1929
E 50440

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50440

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5426 Belair Rd. Rosedale ST. 7-92 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Bishop

(a) RESIDENCE NO. 5426 Belair Rd. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Bishop

6 DATE OF BIRTH (month, day, and year) Jan. 27 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Ship Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Bishop (Address)

15 Filed OCT 26 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1928 to Oct 23 1929, that I last saw him alive on Oct 23 1929, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

1 Acute Cardiac Dilatation

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct 28 1929
20 UNDERTAKER	ADDRESS
Frederick Lassalmotors	Fulton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—1 M. F. S.—500 Blks.

E 50441

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50441 ✓ E 50441

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Gehricke (Gercke)

(a) RESIDENCE NO. 240 S. East ave. ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Gehricke

6 DATE OF BIRTH (month, day, and year) Jan. 22 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Herman Gehricke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ....., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1929, to Oct. 24, 1929, that I last saw him alive on Oct. 24, 1929 and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) ..... M. D.

10-25. 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Iron Lutheran Cemetery	Oct 27 1929
20 UNDERTAKER	ADDRESS
Frederick Eccard Sons	Fullerton Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50442

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH 605 W. 39th. St.

City of Baltimore: (No. 13-57 St., Ward)

2-FULL NAME Hannah L. Cooke

(a) RESIDENCE NO. 605 W. 39th. Street St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of H. Webster Cooke

6 DATE OF BIRTH (month, day, and year)
March 22, 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44	7	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Philadelphia, Pa.

PARENTS

10 NAME OF FATHER Ernest Spiegel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Phila. Pa.

12 MAIDEN NAME OF MOTHER
Mary O'Rourke

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Mrs. Frank H. Gunther
(Address) Charles St. Ave. & Cold Spring Lane

15 Filed OCT 29 1929 19 C. HAMPSON JONES, Registrar
T 2 7 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest I find that said deceased came to death
(autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis

6 Months (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

Oct 25 1929 (Signed) Hilary Bladen, M. D.

, 19 (Address) 1426 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	10/28/29 19

20 UNDERTAKER H. W. Ellicott & Son ADDRESS 865 N. Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50443

CERTIFICATE OF DEATH

24 E 50443

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Mayer

(a) RESIDENCE NO. 1653 McKean Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 10 mos. 15 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work News-boy

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible] 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cape May N. J.

PARENTS

10 NAME OF FATHER Frederick Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Bertha Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington

14 Informant Bertha Mayer (Address) 1653 McKean Ave

15 Filed OCT 27 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929, to Oct 26, 1929 that I last saw h[illegible] alive on Oct 25, 1929 and that death occurred, on the date stated above, at 12.05 a m.

The CAUSE OF DEATH* was as follows:

Meningitis (Meningococcus)

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 1653 McKean Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical findings + spinal puncture

(Signed) Addison Craft Irby, M. D.

10-16, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	10/28 1929
20 UNDERTAKER William Cook	ADDRESS 1317 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50444

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Buskirk (Buskirk)

(a) RESIDENCE NO. 4006 Gough ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Buskirk

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0470

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Buskirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Clise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed OCT 27 1929, 19 C. HAMPSON JONES, M. D. Registrar

T 2 7 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 19 29 to Oct. 24, 19 29

that I last saw him alive on Oct. 24, 19 29

and that death occurred, on the date stated above, at 10:35 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Myocarditis chronic Senile Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. & X-ray

(Signed) Warren M. Wheeler M. D.

10-25 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Oct 28th 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50445

CERTIFICATE OF DEATH

31

E 50445

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gladys Atkins

(a) RESIDENCE NO. 1235 N. Broadway ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Raymond Atkins

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Lloyd

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Elsa Brooks

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed OCT 27 1929, 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 19 29, to Oct. 26, 19 29,

that I last saw her alive on Oct. 26, 19 29

and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jas. Hurnold Jr. M. D.

10-26 19 29 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bauchman's Cem	10/27 1929
20 UNDERTAKER William Cook	ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

T 27 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 50446 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 50446

CERTIFICATE OF DEATH 49 E 50446

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., 9-46 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Seibert

(a) RESIDENCE NO. 1558 E. 28th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Seibert

6 DATE OF BIRTH (month, day, and year) Aug 30 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Constance C. Siebert

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Kielich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna M Siebert

(Address) 1508 E 28th St

15 FILED OCT 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 1929 to Oct 24 1929

that I last saw him alive on Oct 24 1929

and that death occurred, on the date stated above, at 4:00 p m.

The CAUSE OF DEATH* was as follows:

Tumor, Cerebral; Arterio-Sclerosis, General

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into Cerebral Tumor (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Oct 23, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical; laboratory & Pathological

(Signed) Lewis P. Gundry, M. D.

10-24 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 28th 1929
20 UNDERTAKER D. Wm Cook 1217	ADDRESS St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

50447 ✓ 5-0447

E 50447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-006 50447

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2307 W. Lafayette Ave WARD 24-15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles R. Haslup

(a) RESIDENCE NO. 2307 W. Lafayette Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Haslup

6 DATE OF BIRTH (month, day, and year) Dec. 20-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Cashier 09

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa

PARENTS

10 NAME OF FATHER John Haslup

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna M. Haslup

(Address) 2307 W. Lafayette Ave

15 Filed OCT 27 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to Oct 26, 1929, that I last saw h.. alive on Oct 23, 1929 and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

About 1 hour (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hyp. H. D. Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

10/26, 1929 (Address) 11 Professional Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Holly Springs Pa	Oct. 29 1929
20 UNDERTAKER	ADDRESS
Chas. E. Isaac	802 Madison Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 15-2 50448

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Edna C Morton

(a) RESIDENCE NO. Forest Hill, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced, HUSBAND of or) WIFE of W. D. Morton ?

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 37 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: H. S Bailey (Address) Darlington Md.

15 Filed 19 Registered

C. HAMPSON JONES, M. D.

Per

10 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929, to Oct 27, 1929, that I last saw h.. alive on Oct 27, 1929, and that death occurred, on the date stated above, at 3:10 A. m.

The CAUSE OF DEATH* was as follows:

Septicemia (Staphylococcus)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carbuncle of neck

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) J Frank Hewett, M. D.

Oct 27, 1929 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Hill Md. | DATE OF BURIAL: 10-29, 1929

20 UNDERTAKER: H. S Bailey | ADDRESS: Darlington Md.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50449

CERTIFICATE OF DEATH.

H 50449

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2927 Harlem Ave (Street) 6-17 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil G. Pfeiffer

(a) RESIDENCE NO. 2927 Harlem Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora R. Pfeiffer

6 DATE OF BIRTH (month, day, and year) Jan 9. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer) Gaulke Bros

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dora R. Pfeiffer

(Address) 2927 Harlem Ave

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Oct. 25, 1929, that I last saw him alive on Oct 24, 1929, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Gastric Hemorrhage 12 days

Myocarditis 10 "

(duration) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray & G. I. Series

(Signed) J. M. Dellinger, M. D.

Oct 26 1929 (Address) 621 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Oct 28 1929
20 UNDERTAKER	ADDRESS
Mrs. John W. Pfeifer & Son	80 W. Fayette

T 2 7 1929

INSTRUCTIONS—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50450

CERTIFICATE OF DEATH

★ 146 E 50450

1—PLACE OF DEATH Prudent Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 14 ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebe Butler

(a) RESIDENCE NO. Draper Md. Bx #19 ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	ed	Wife

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2 - 1908

7 AGE	Years	Months	Days	If LESS than 1 day,....hrs. or....min.
	21	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Elizabeth Bentley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant John Butler father
(Address) Milton Del

15 Filed ....., 19.. C. HAMPSON JONES, M. D.
Registrar

C 1271929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26-29

17 I HEREBY CERTIFY, That I attended deceased from 10-22 1929, to 10-26 1929,

that I last saw h alive on 10-26-29, 19....

and that death occurred, on the date stated above, at 7 51 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Sepsis
(Following 7 mo. Stillbirth-3 wks prior)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) W. H. Butler, M. D.

, 19 (Address) Prudent Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Middletown Del	Oct 29 1929
20 UNDERTAKER	ADDRESS
E. R. Brown & Son	Wilmington

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50451

CERTIFICATE OF DEATH.

60-02 50451

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Rossiter Ave ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Charlotte McClung

(Residence in Baltimore: No. 521 Rossiter Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Dec 24, 1880 (Month) (Day) (Year)

7-AGE, 48 yrs. 10 mos. 1 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Wife

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Sullivan

11-BIRTHPLACE OF FATHER (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Margt

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine McClung

(Address) 521 Rossiter Ave

15-

Filed ..... 191..... Registrar.

C. HAMPSON JONES, M. D.

T 2 7 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1929 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 20 1929, to Oct 25 1929, that I saw her alive on Oct 25 1929, and that death occurred, on the date stated above, at 8-45 p m

The CAUSE OF DEATH* was as follows:

Infected Gall bladder

Old chronic thyroid for yrs

(Duration) yrs. mos. ds.

Immediate cause of death Myocarditis

CONTRIBUTORY (Secondary) cardiac dilitation 6 days

(Duration) yrs. mos. ds.

(Signed) H. L. Barnes M. D.

Oct 28th 1929 (Address) 634 Garrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs mos. ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Marys Govans — DATE OF BURIAL, Oct 29 1929

20-UNDERTAKER Rife Wright & Ault — ADDRESS 914 Fremont Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 50452

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Rutland Ave. ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christian J. Smith

(a) RESIDENCE NO. 1805 Rutland Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor Wagner

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clain Revisor

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Margaret Connelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Miss Annie Smith

(Address) 1228 E. North Ave

15 Filed OCT 27 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-25-29

17 I HEREBY CERTIFY, That I attended deceased from 10/24/29, 19 , to 10/25, 19 29 that I last saw him alive on 10/25, 19 29 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

1 Myocardial Insufficiency
2 Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Nuttall, M. D.

10/26 19 29 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Oct. 28 1929
20 UNDERTAKER	ADDRESS
Rita Wiedefeld 914	Fremont Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50453

CERTIFICATE OF DEATH

90 E 50453

1-PLACE OF DEATH

City of Baltimore: (No. 402 E. Gittings St. St. 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah V. Earle.

(a) RESIDENCE NO. 402 E. Gittings St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow.

5a If ~~married, widowed, or divorced~~ widowed, HUSBAND of ~~HUSBAND of~~ William B. Earle.

6 DATE OF BIRTH (month, day, and year) September 19, 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Herman C. Anderson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Rachael A. Shipley.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Margaret O'Loughlin. (sister)
(Address) 334 S. Payson St.

15 Filed OCT 27 1929 19 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leinhard, M. D.

10/26 1920 (Address) 1011 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 28, 1929
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 50454

B 50454

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 70-20 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Balter or Maggie Kulikauskytis

(a) RESIDENCE No. 400 Gwynn Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Ignatius Balter

6 DATE OF BIRTH (month, day, and year) 9 1 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Wm Spicer

(Address) 400 Gwynn Ave

15 FILED ..... 19 ..... Registrar

OCT 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 - 24 1929

17 I HEREBY CERTIFY, That I attended deceased from 10 - 21 1929 to 10 - 24 1929,

that I last saw her alive on 10 - 24 1929

and that death occurred, on the date stated above, at 12.10 P m

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
(right upper lobe)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Oct. 28 1929
20 UNDERTAKER Frank A. Witzke, 1531 W. Lombard	ADDRESS St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

230462 E 50455

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 49 ✓ E 50455

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. D-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin Meyrowitz

(a) RESIDENCE NO. 1024 Bolton St ST. Nw WARD York-City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Florence

6 DATE OF BIRTH (month, day, and year) 4/17/01

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pharmacy

(b) General nature of industry, business, or establishment in which employed (or employer) 025

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Roumania

PARENTS

10 NAME OF FATHER Carl Meyerowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rumania

12 MAIDEN NAME OF MOTHER Esther Blattstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rumania

14 Informant Friends—
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Oct 27 1929, that I last saw h... alive on Oct 27 1929 and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows: Brain Tumor, Glioma (malignant)

1 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? New York City

Did an operation precede death? Yes Date of Oct 25, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Harold Gardner M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York

DATE OF BURIAL 10/27/29

20 UNDERTAKER J. Ahern & Co

ADDRESS 2432 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50456 X 45 E 50456

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Hosp. for Women of Md. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Virginia Dennis Page

(a) RESIDENCE NO. Princess Anne, Somerset Co., Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If [redacted]; widowed, [redacted] (or) WIFE of Henry Page

6 DATE OF BIRTH (month, day, and year) Feb. 20, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Berlin
(State or country) Worcester Co., Md.

PARENTS

10 NAME OF FATHER John Upshur Dennis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Worcester Co., Md.

12 MAIDEN NAME OF MOTHER Louisa Jane Holland

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Worcester Co., Md.

14 Informant Dr. Alfred P. Dennis
(Address) U.S. Tariff Comm. Wash. D.C.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1929, to Oct. 27, 1929.

that I last saw h[redacted] alive on Oct. 27, 1929

and that death occurred, on the date stated above, at 4:40 p. m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)
Myocardial failure (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 23, 1929

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Alfred P. Dennis, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Princess Anne Md	Oct 28 1929
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Sons	McDaniel St. Cambridge Md

OCT 28 1929 H. A. JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 ✓ E 50457

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5203 Roland Ave. ST. 13-55 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie B. Coggins

(a) RESIDENCE NO. 5203 Roland Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Coggins

6 DATE OF BIRTH (month, day, and year) Jan. 9, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Elisha S. Heath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Harriet S. Chapin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant Charles W. Coggins

(Address) 5203 Roland Ave.

15 Filed ..... 19 ..... Registrar

OCT 26 1929 HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1929, to Oct. 25, 1929, that I last saw h[illegible] alive on Oct. 25, 1929 and that death occurred, on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

6 hours.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Colitis -

(duration) 3 yrs. + mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Preceding Pain.

(Signed) M. Gibson Porter, M. D.

10/26 1929 (Address) 4822 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Oct. 28, 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons,	1900 Eutaw Pl.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 50458

CERTIFICATE OF DEATH.

90 ✓

E 50458

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 216 Northway St. 27-49 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Martin

(a) RESIDENCE NO. 216 Northway St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann Martin

6 DATE OF BIRTH (month, day, and year) Apr 4 1837

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	92	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 634

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Martin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Eldtrecht

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Theodore A Martin

(Address) 216 Northway

15 Filed 19 R Ott Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and from the evidence obtained by said Inquest, found that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis Stroke

2 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) H. M. Morrison M. D.

(Coroner)

Oct 28 1929 (Address) 3622 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem Date of Burial Oct 28 1929

20 UNDERTAKER John O Mitchell and Son ADDRESS 1000 Eutaw Place

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50459 — 129 ✓ E 50459

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. 11-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Murray

(a) RESIDENCE NO. 1029 Druid Hill Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	~~Unknown~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Murray ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed OCT 28 1929 19 HAYDEN JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1929 to Oct. 25, 1929

that I last saw h... alive on Oct. 25, 1929

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic

Myocarditis " "

(duration) over 3 mos. ? ds.

CONTRIBUTORY (Secondary) Hypertension; Arteriosclerosis

(duration) over 3 mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Tuberculin Test

(Signed) Marvin M. McLean, M. D.

10-26, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	10-27, 1929
20 UNDERTAKER Reed & Conroe	ADDRESS 916 Cathedral

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50460

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50460

90 ✓

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Ricker

(a) RESIDENCE NO. 606 Cumberland ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Holloday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed OCT 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1929, to Oct. 23, 1929, that I last saw her alive on Oct. 23, 1929 and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) over 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Pneumonia, Influenza ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. H. H. Welch, M. D.

10-24, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	10-27 1929
20 UNDERTAKER Leonard Easton	ADDRESS 916 Park ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 50461

Spec.—1-10-21—M&T—1500 Rls.

E 50461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 1-24 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lemuel Baylor

(a) RESIDENCE NO. 1209 Park Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith (Mone) Baylor

6 DATE OF BIRTH (month, day, and year) March 4, 1896

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
33	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common laborer

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) King William County Virginia

PARENTS

10 NAME OF FATHER Solomon Baylor

11 BIRTHPLACE OF FATHER (city or town) King William (State or country) County, Virginia

12 MAIDEN NAME OF MOTHER Julia

13 BIRTHPLACE OF MOTHER (city or town) King William (State or country) County Virginia

14 Informant Hospital Records (Address)

C. E. THOMPSON-JONES, M.D.

15 Filed OCT 28 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 1929

I HEREBY CERTIFY, That I attended deceased from October 7, 1929, to October 25, 1929, that I last saw him alive on October 25, 1929, and that death occurred, on the date stated above, at 9.05 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (miliary)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Geo. A. Thompson M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lester Manor Va	10-28 1929
20 UNDERTAKER Daniel Easton	ADDRESS Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50462

CERTIFICATE OF DEATH.

E 50462

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3202 Fernhill Ave ST. 18 WARD 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Kapfer

(a) RESIDENCE No. 3202 Fernhill Ave ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Kapfer.

6 DATE OF BIRTH (month, day, and year) Aug 6 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Sheet Metal Workers

(c) Name of employer Wm E Wood Co

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John F Kapfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Reuding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret M Kapfer.

(Address) 3202 Fernhill Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 7, 1928, to Oct 27, 1929.

that I last saw him alive on Oct 26, 1929.

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Mitral Regurgitation (duration) yrs. 4 mos 23 ds.

CONTRIBUTORY (Secondary) (duration) Don't know mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O H Duvall, M. D.

10/27 1929 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Oct 30 1929
20 UNDERTAKER Harry T Amacost & Son	ADDRESS Edgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 01929 HAMILTON JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1124

E 50463

REGISTERED NO. E 50463

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 52 Orchard St., (Ward) 17-24th

2-FULL NAME Rev Jeannette N. L. Johns

(a) RESIDENCE NO. 521 Orchard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer) 018
(c) Name of employer

9 BIRTHPLACE (city or town) Wash D. C.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Susan Smith

13 BIRTHPLACE OF MOTHER (city or town) Wash Dc
(State or country)

14. Informant Jessie Hylton
(Address) 803 Rutland Av

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 25th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

Shock

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Error of diet

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Church Fair

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. H. Leitch, M. D.

(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Oct 29 1924
20 UNDERTAKER Samuel Wemley	ADDRESS 578 N Bond

OCT 26 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 50464

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1408½ Madison Ave 14-20 Ward)

2-FULL NAME Mary F Johnson

(a) RESIDENCE NO. ~~1408½ Madison~~ St., Ward

(Usual place of abode) 736 Wilkens

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 637
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Horace Stepney

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hannah Squilla
(Address) 736 Wilkens

15 Filed ... 19... HARRY J. JONES, M. D.
OCT 26 1929
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 25th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest ... (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

... (duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) ...

... (duration) yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? 736 Wilkens

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

Signed Harry J. Haskins, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levy Bros

DATE OF BURIAL Oct 28 1929

20 UNDERTAKER Samuel I. Newsley

ADDRESS 1 Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

50465 89 E 50465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) En route to University Hospital (St., Hospital or Ward)

2-FULL NAME Adam Leazer

(a) RESIDENCE NO. 1104 Peach Alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Leazer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Wagon
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER John Leazer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Samuel Wiggins
(Address) 1104 Peach Alley

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour) October 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feltz M. D.

10/26 1929. (Address) 2734 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Allum Cemtery	10/28 1929
20 UNDERTAKER	ADDRESS
Walter B. Spriggs	1322 W Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

* 84 ✓ E 50466

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Durham

(a) RESIDENCE NO. 126 Kingston Road St., Ward

(Usual place of abode) Middle River (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Cora J. Durham

6 DATE OF BIRTH (month, day, and year) March 12, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or mio.
	43	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Cora J. Durham
(Address) 3512 Hickory Ave.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Eugene Tillett, M. D.
10/27 1929 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Oct. 29 1929
20 UNDERTAKER	ADDRESS
Horace F. Burgee	1631 Falls Road

OCT 28 1929 HAMILTON JONES M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001 ✓ E 50467

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5943 Falls Road ST. 27-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie A. Brenize

(a) RESIDENCE NO. 5943 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph K. Brenize

6 DATE OF BIRTH (month, day, and year) April 21-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Jacob Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Barbara Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. F. L. Atherley

(Address) 5943 Falls Road

15 Filed OCT 28 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26-1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to Oct. 26, 1929, that I last saw h[illegible] alive on Oct 26, 1929 and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema.

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

Oct 27 1929 (Address) 3429 Chest. St Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Oct. 28-1929.

20 UNDERTAKER Horace F. Burgee ADDRESS 3631 Falls Road.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 50468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50468

1-PLACE OF DEATH

City of BALTIMORE: (No. 1735 Bolton St. 14-70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne E. Sutton

(a) Residence No. 1735 Bolton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. Life ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed, or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John L. Sutton

6-DATE OF BIRTH (month, day and year) Nov 17 1860

7-AGE. 68 yrs. 11 mos. 8 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home duties
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John J. Dobbin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto -

12-MAIDEN NAME OF MOTHER. Mary E. Jenkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) John L. Sutton (Address) 1735 Bolton St.

15- Filed, 192 Registrar

00 26 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Oct 25 1929

17- I HEREBY CERTIFY, That I attended deceased from Abt Oct 1 1929, to Oct 25 1929.

That I last saw h alive on Oct. 23 1929.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation
with Pulmonary Oedema
Had been bedridden for several years but able to walk about room a few times

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm B Ridez, M. D.

Oct 27, 1929 (Address) Owings Mills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Oct 28 1929

20-UNDERTAKER: Wm. O. Mitchell & Sons — ADDRESS

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50469

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 50469

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3219 N. Calvert St. ST. 12-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Ann Dove

(a) RESIDENCE NO. 3219 N. Calvert St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	

7a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel B. Dove

6 DATE OF BIRTH (month, day, and year) Jan. 11, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md.

PARENTS

10 NAME OF FATHER Benj. I. Phipps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Suit

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Herbert U. Dove

(Address) Garden Apts.

15 Filed OCT 29 1929, 19 Rook, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/29.

17 I HEREBY CERTIFY, That I attended deceased from Oct 21 1929 to Oct 27 1929.

that I last saw h[illegible] alive on Oct 27 1929

and that death occurred, on the date stated above, at 3.00 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) c

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam's

(Signed) H A Dudds, M. D.

Oct 28 1929 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct. 29, 1929

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

M. B. Mitchell

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50470

CERTIFICATE OF DEATH

160

E 50470

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hosp 15-21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Crawford

(a) RESIDENCE NO. 622 Gold ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
-	7	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Crawford

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Johnson

(Address) 622 Gold St.

15 Filed OCT 29 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1929.

17 I HEREBY CERTIFY, That I attended deceased from 10-7- 1929, to 10-26- 1929, that I last saw h[illegible] alive on 10-26-29, 19 29 and that death occurred, on the date stated above, at 10:10 A.m.

The CAUSE OF DEATH* was as follows:

Hanition

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Patellar reflex -

(Signed) C. L. Jackson M. D.

10/26 19 29 (Address) 600 N. Arlington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cem	Oct 28 1929
20 UNDERTAKER	ADDRESS
Sam'l H. Chase & Son	[redacted] Mosher

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50471

CERTIFICATE OF DEATH.

129 50471

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Patterson Park Ave WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Rockkind

(a) RESIDENCE NO. 5031 Wennore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced wife of Abraham Rockkind

6 DATE OF BIRTH (month, day, and year)

7 AGE: 45 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Rockland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abraham Rockkind

(Address) 1439 E Balt St

Filed OCT 2 6 1929 19

C. HAMPSON JONES, M.D.

Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1929 to Oct 25, 1929.

that I last saw her alive on Oct 25, 1929,

and that death occurred, on the date stated above, at 12.10 p m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis + Regurgitation

C Congestive Cardiac Failure

5 months (?) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchym. Nephritis

work (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical history + findings

(Signed) Jacob H Cohn M. D.

10/25, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dittrich Int ramal — DATE OF BURIAL 10/28 1929

20 UNDERTAKER Jacob Lewis — ADDRESS 1439 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50472

REGISTERED NO. 15-58

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4210 Parkside ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Livingston

(a) RESIDENCE NO. 4210 Parkside Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Livingston

6 DATE OF BIRTH (month, day, and year) Dec 15-1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9 10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Louis

(Address) 1439 E Balt St

15 Filed OCT 28 1929 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Oct 25, 1929, that I last saw h. alive on Oct 25, 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Meyer Muller M. D.

10/28, 1929 (Address) 3649 Pk (Hospital)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hermon Rem — DATE OF BURIAL 10/28 1929

20 UNDERTAKER Jack Louis — ADDRESS 1439 E Balt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

E 50473

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50473

91-002

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Dorbitz

(a) RESIDENCE NO. Preston + Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Dorbitz

6 DATE OF BIRTH (month, day, and year) Oct 3rd 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Little Sisters of the Poor

(Address) Preston + Valley

15 Filed OCT 28 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 25 Oct. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 25, 1929, that I last saw h.... alive on Oct 24, 1929 and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Benson Wells, M. D.

Oct 26 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct. 29 1929
20 UNDERTAKER	ADDRESS
Lilly + Sons Inc.	402 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50474

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50474

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3114 Elliott ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frauke Wolfermann

(a) RESIDENCE NO. 3114 Elliott ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Wolfermann

6 DATE OF BIRTH (month, day, and year) Aug 26 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Coffee Mfg

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Wolfermann

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Huber

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mary A. Wolfermann

(Address) 3114 Elliott St.

15 Filed OCT 28 1926 C. HAWKINS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25/26

17 I HEREBY CERTIFY, That I attended deceased from Sept 10 1926 to Oct 25 1926

that I last saw h alive on Oct 25 1926

and that death occurred, on the date stated above, at 5½ P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) W. S. Magee M. D.

10 Oct 1926 (Address) 2612 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Oct 28 1926
20 UNDERTAKER	ADDRESS
Lilly Funeral Home	1003 N. Mount St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

E 50475

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md.

CITY OF BALTIMORE: (No. 40-51 St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orla Nielsen

(a) RESIDENCE NO. 26 South St., New York City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A.B. Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Frederic Ewing

9 BIRTHPLACE (city or town) Copenhagen (State or country) Denmark

PARENTS

10 NAME OF FATHER Axse Nielsen

11 BIRTHPLACE OF FATHER (city or town) Copenhagen (State or country) Denmark

12 MAIDEN NAME OF MOTHER Marie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Records, U.S. Marine Hospital (Address)

15 Filed OCT 28 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 19 29

17 I HEREBY CERTIFY, That I attended deceased from October 17, 19 29, to October 26, 19 29, that I last saw him alive on October 26, 19 29, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Malaria, ~~tertian and quartan~~

Estivo-Autumnal

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? laboratory & clinical

(Signed) Ralph E Porter M. D.

10/26, 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's, Hampden	Oct 28, 1929
20 UNDERTAKER E. LeRoy Stifflen Inc.	ADDRESS 128 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACTLY what is meant by OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Shower

E 50476 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50476

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH Church Home & Infirmary 29

CITY OF BALTIMORE: (No. N. Broadway ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Cordelia Shawer

(a) RESIDENCE NO. Church Home & Infirmary ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 23 - 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manchester Md

PARENTS

10 NAME OF FATHER W. Jacob Shower

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester Md

12 MAIDEN NAME OF MOTHER Mary Eberhard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manchester Md

14 Informant Mrs. M. S. H. Unger

(Address) Westminster Md

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1929, to Oct. 28, 1929

that I last saw her alive on Oct. 27th, 1929

and that death occurred, on the date stated above, at 6 40 a. m.

The CAUSE OF DEATH* was as follows:

Senile dementia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Senility, Arteriosclerosis

Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herman H. Norwood, M. D.

, 19 (Address) Church Home Infirmary

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Md.	Oct 31 1929

20 UNDERTAKER Jacob Winter's Sons ADDRESS Manchester Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 2 1929 H. HAMPSON GIBBS, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50477

CERTIFICATE OF DEATH.

23

E 50477

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Cathedral St., St. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor A. Howard.

(a) RESIDENCE No. 1025 Cathedral St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sedgley Howard.

6 DATE OF BIRTH (month, day, and year) July 10, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Burlington N. Carolina

PARENTS

10 NAME OF FATHER George Walter Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Betty Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Mr. Sedgley Howard. (Address) 1025 Cathedral

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1929, to Oct 26, 1929.

that I last saw h[illegible] alive on Oct 26, 1929.

and that death occurred, on the date stated above, at 12.40 P.m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

10-28-1929 (Address) St Paul & Preston Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	10/29 1929
20 UNDERTAKER	ADDRESS
Herriman & Son	N. Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

OCT 28 1929 [illegible] HAMBLETON JOYES, M. D.

Spec.—1-12-23—M&T—500 Bks.

TORTOLANI

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50478 ✓5 E 50478

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No. 1000 Caton Ave St 11-24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Tortolani

(a) RESIDENCE No 1009 ? Cathedral ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8 Sept 2nd 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rohde Island

PARENTS

10 NAME OF FATHER Alfonso Tortolani

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Erminia Corsi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Jenkins Memorial Hosp. 1000 Caton Ave

15 Filed ..... 19 ..... Registrar

OCT 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1929, to Oct. 28, 1929, that I last saw him alive on Oct. 27, 1929, and that death occurred, on the date stated above, at 7-30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of unknown

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brauer, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 10-30 1929

20 UNDERTAKER Mrs Chas A G Rohde ADDRESS 2327 Amsterdam Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50479 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH

49 E 50479

1—PLACE OF DEATH

REGISTERED NO. 13-52

CITY OF BALTIMORE: (No. 3511 Roland Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ellen Wheeler

(a) RESIDENCE NO. 3511 Roland Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	W.	Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David H. Wheeler

6 DATE OF BIRTH (month, day, and year) Mar 7, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md.

PARENTS

10 NAME OF FATHER Jerome Tyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md.

12 MAIDEN NAME OF MOTHER Kate Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md.

14 Informant Mrs. W. Wheeler
(Address) 3511 Roland Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1928, to Oct 27, 1929, that I last saw her alive on Oct 26, 1929 and that death occurred, on the date stated above, at 5-52 a.m.

The CAUSE OF DEATH* was as follows:

carcinoma of Spine

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) [illegible] M. D.

10/27/29 (Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Oct 29 19

20 UNDERTAKER D S Marshall ADDRESS 5539 Belair Rd

N. B.—WHETHER PERSON, WITH CONSENT OF WHOM, OR BY WHOM INFORMATION IS GIVEN, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Mail 495 S Pulaski

HEALTH DEPARTMENT—CITY OF BALTIMORE

50480

CERTIFICATE OF DEATH

100-001 L 50480

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 S. Decker ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alvin F. D. Miller

(a) RESIDENCE NO. 529 S. Decker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Robt E. Miller

11 BIRTHPLACE OF FATHER (city or town) Ga
(State or country)

12 MAIDEN NAME OF MOTHER Brett Cousin

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14
Informant Robert E. L. Miller
(Address) 529 S. Decker St

15
Filed OCT 26 1929 19 RHK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-26-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22 1929, to Oct 26 1929,
that I last saw him alive on Oct 25 1929
and that death occurred, on the date stated above, at 2 30 m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Cardiac Failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. E. Neer M. D.

(Address) 408 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Memorial	Oct. 28 1929

20 UNDERTAKER Wm Cole ADDRESS 217 S. Patterson Park Ave

16. BE SURE TO WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50481

CERTIFICATE OF DEATH

57 E 50481

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital 9-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Biehl

(a) RESIDENCE NO. 922. N. Castle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Ignatz Biehl

6 DATE OF BIRTH (month, day, and year) June 13 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Housewife 037

(b) General natore of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Ignatz Biehl
(Address) 922 N Castle St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26-29

17 I HEREBY CERTIFY, That I attended deceased from 10-22, 1929, to 10-26, 1929.

that I last saw h.e alive on 10-26, 1929

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetic gangrene

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Denial

(Signed) ... M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Oct 30th 1929

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

Be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 50482

1—PLACE OF DEATH — REGISTERED NO. E 50482

CITY OF BALTIMORE: (No. 1521 Inc ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Jenkins

(a) RESIDENCE NO. 1521 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Emma Skinner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn

14 Informant:
(Address):

15 Filed Oct 4 1929 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 27-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 24. 1929, to Oct. 27 1929, that I last saw h. alive on Oct. 26 1929, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Kerby M. D.

, 19 (Address) 1021 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS OCT 28 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item must be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50483

100-001

E 50483

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1115 E Pratt St., 35 Ward)

2-FULL NAME Sadie A R Gibson

(a) RESIDENCE NO. 1115 E Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Oct 31 1928

7 AGE: Years — Months: 11 — Days: 25 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: J B Gibson

11 BIRTHPLACE OF FATHER (city or town): Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER: Ryona May Parks

13 BIRTHPLACE OF MOTHER (city or town): Somerset Co Md.
(State or country)

14 Informant: UNIVERSITY OF MARYLAND
(Address)

15 Filed....., 19..... Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

6 Laudnum (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

What autopsy? —

What test confirmed diagnosis? —

Oct 29 By G Hyslop

(Signed) G C Hodes, M. D.

, 19 (Address) 1438 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health

ADDRESS

OCT 28 1929

Per Wm. B. Rouse

Cor.—12-9-25—A Co.—200 Bks.

E 50484

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 50484

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 213 S Dallas St. 3-4 Ward)

2-FULL NAME Thomas Harlens

(a) RESIDENCE NO. 213 S Dallas St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 67

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed..... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
Coroner

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

37

OCT 28 1929 UNIVERSITY OF MARYLAND
OCT 28 1929 Commissioner Health
OCT 28 1929 THE MORGAN

Spec.—1-12-23—M&T—500 lbs.

E 50485

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50485

CERTIFICATE OF DEATH

STATE BIRTH No. 161-001 [illegible]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home and Infirmary (6-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Kahzer

(a) RESIDENCE NO. 156 North East Avenue WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) October 26, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Kahzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Herrmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Father.

(Address)

15 Filed [illegible], 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 26 1929

17

I HEREBY CERTIFY, That I attended deceased from October 26, 1929 11:20 A.M. to October 26, 1929, 11:20 A.M.

that I last saw h[illegible] alive on October 26, 1929,

and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Intrauterine Asphxia

Prematurity, 6 months.

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Maternal Placenta Previa, Centralis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pregnancy. ✓

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) [illegible], M. D.

(Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Home & Infr.

DATE OF BURIAL 19

20 UNDERTAKER [illegible]

ADDRESS

OCT 28 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

382

[illegible] 2 1929 [illegible] JONES, M. D. Commissioner Health

PRINTED IN U.S.A.

Spec.—2-29-28—L. F. S.—600 Bks.

E50486. HEALTH DEPARTMENT—CITY OF BALTIMORE E50486

CERTIFICATE OF DEATH

111-001

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 33rd & Calvert ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Murray K. Martin

(a) RESIDENCE NO. 7 East 39th St ST., Baltimore WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Murray K Martin

6 DATE OF BIRTH (month, day, and year) Oct 16, 1882

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
47	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Interior Decorator

(b) General nature of industry, business, or establishment in which employed (or employer) 63 0

(c) Name of employer

9 BIRTHPLACE (city or town) Emmettsburg Md.
(State or country)

PARENTS

10 NAME OF FATHER George M. Martin

11 BIRTHPLACE OF FATHER (city or town) Emmettsburg
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ellen

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Margaret M Martin
(Address) 7 E 39 St.

15 Filed OCT 26 1929 WILLIAM H. JAMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 26/29

17 I HEREBY CERTIFY That I attended deceased from Oct 8, 1929, to Oct 26, 1929, that I last saw h... alive on Oct 26, 1929 and that death occurred, on the date stated above, at 9.14 P m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs mos. 20 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Thompson, M. D.

10/26, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Oct 29 1929
20 UNDERTAKER H M Routson	ADDRESS 2238 N Milton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E50487 HEALTH DEPARTMENT—CITY OF BALTIMORE E50487

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1738 Homestead ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME WALTER M. LAUTENBERGER

(a) RESIDENCE NO. 1738 Homestead ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 4 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice M. Brown

6 DATE OF BIRTH (month, day, and year) June 15, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Mfr Clothing

(c) Name of employer Moses & Co

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William P Lautenberger

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catharine Bried

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Alice M Lautenberger
(Address) 1738 Homestead St

15 Filed ..... 19 ..... Registrar

OCT 28 1929 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 19 29 to Oct 27 19 29

That I last saw h... alive on Oct 27 19 29

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
(Mitral Insufficiency)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John R Heuchow M.D.

19 (Address) 357 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Oct 29 1929
20 UNDERTAKER	ADDRESS
W M Routzon	2238 W North Ave

A B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 5-0488

HEALTH DEPARTMENT—CITY OF BALTIMORE

178 E. 5-0488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Smith

(a) RESIDENCE NO. 1806 Presbury St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella C. Smith

6 DATE OF BIRTH (month, day, and year) Nov 19-1862

7 AGE	Years	Months	Days
	66	11	8

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr Hopkins

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Benj Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Heckels

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs Ella C. Smith

(Address) 1806 Presbury St

15 Filed....., 19..... Registrar

THOMPSON JONES, M. D.

OCT 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental

Smoke Asphyxia

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

Duration ..... yrs. ..... mos. ..... ds.

Oct 27 1929 G. E. Stadel M. D.

(Date) (Coroner)

(Address) 143 Hoo Away

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern Cemetery

Date of Burial Oct 29 1929

20 UNDERTAKER H. J. Tuckers, Sons

ADDRESS Fort Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E. 50489

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 50489

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. E-17 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael J. Ward.

(a) RESIDENCE NO. 1418 N. Bond St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella M. Ward

6 DATE OF BIRTH (month, day, and year) November 27th. 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	66	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Jeremiah Ward.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs Nellie Patterson,

(Address) 1418 N. Bond St.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

CT 28 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27th. 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

Chr. Nephrotis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. McCabe M. D.

(Coroner)

10-28-1929 (Address) 508 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery. Date of Burial 10/ 29. 1929

20 UNDERTAKER Chas. P. Bruce & Son ADDRESS 118 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 5-0490

E. 5-0490

CERTIFICATE OF DEATH. 1179

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Universal Hospital St. 4-30 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Walsh

(a) RESIDENCE NO. Cockeysville Md St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Ireland

(State or country)

PARENTS

10 NAME OF FATHER Andrew Walsh

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Ireland

14 Informant: Sister Stanislaus McManus

(Address) Cold Spring Lane

15 Filed....., 19.....

OCT 28 1929

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27 1929

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns - Second & third degree - over entire body surface

8 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical shock

8 hrs

(duration) yrs. mos.

(Signed) Eugene Zilbert M. D.

(Coroner)

10/27, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. 8 hrs ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Cockeysville, Md.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial: Oct 31 1929

20 UNDERTAKER: Rita Riedfeld — ADDRESS 914 Drummond Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Blks.

E 50491

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50491

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2—FULL NAME Mary Downey

(a) RESIDENCE NO. Preston & Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Downey

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Casey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley Sts

15 Filed OCT 28 1929, 19 [illegible] Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27th 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 27, 1929, that I last saw h alive on Oct 26, 1929 and that death occurred, on the date stated above, at 7.30 p. m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Clemson Jones, M. D.

10/28/29 (Address) 1716 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cumberland Md	Oct 28 1929
20 UNDERTAKER Peter M. Midkiff	ADDRESS 91st Fremont Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 50492

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50492

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1611 Normal Ave. ST., 8-W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriett E. Turpman

(a) RESIDENCE NO. 1611 Normal Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Late) John F. Turpman

6 DATE OF BIRTH (month, day, and year) Oct 24 1853.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Abraham Forney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Emma C. Burgess

(Address) 1611 Normal Ave.

15 Filed OCT 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28, 1929.

17 I HEREBY CERTIFY That I attended deceased from June 27, 1929 to Octobr 28, 1929, that I last saw h alive on Octobr 28, 1929, and that death occurred, on the date stated above, at 9.25 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach Liver and Intestines

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia Metastasis.

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Albert A. Ruehrg., M. D.

10/30 1929 (Address) 2025 Eutaw Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thurmont Md

DATE OF BURIAL 10/31 1929.

20 UNDERTAKER Thurmont Bar.

ADDRESS 315 Chestnut

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E. 50493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E. 50493

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital (WARD) 13-52

2—FULL NAME Harvey Mathias

(a) RESIDENCE NO. 706 W 34th St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Nov. 27, 1866

6 DATE OF BIRTH (month, day, and year) ~~Oct. 27, 1924~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment) in which employed (or employer) Laying underground

(c) Name of employer Cable for telephone Co

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Cornelius Mathias

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Shute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Mathias

(Address) 706 W. 34th St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to Oct 27, 1929, that I last saw h. alive on Oct 27, 1929 and that death occurred, on the date stated above, at 5:20 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Chronic, Emphysema Syphilitic Cardio vascular Disease Endocarditis + aortic Insufficiency Nephritis, Arteriosclerotic (duration) Arteriosclerosis Syphilis yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs mos 3 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. Symp. Physicians. Autopsy

(Signed) H. Glenn Sanchez, M. D.

10/27, 1929. (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	10/29, 1929
20 UNDERTAKER	ADDRESS
Emmert & Son	34 Woodlawn Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 29 1929 C. HAMPSON JONES, M.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Isenberg ✓ 2027 E. North Ave

E50495

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 E.50494

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1228 Federal ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles D Bloom

(a) RESIDENCE NO. 1228 Federal ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche E Bloom

6 DATE OF BIRTH (month, day, and year) Oct 16 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Gas & Electric Co

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Adam Bloom

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Muller

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mrs Smith

(Address) 310 S Howard Ave

15 Filed ..... 19 ..... Registrar

CT 28 1929 C. HAMPSON JONES M.D. AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1929

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1929, to October 26, 1929, that I last saw h.. alive on October 26, 1929 and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

a Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Prostatectomy

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? Yes Date of Oct 21 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Allen Cumming Jr M. D.

1929. 19 (Address) 1228 E Fed St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	10/29 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 30428
E. 50495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E. 50495

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. JOHNS HOPKINS HOSPITAL ST., 6-4 WARD)

2—FULL NAME Charlotte McCleary

(a) RESIDENCE NO. 1744 Orleans ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): ~~Widow~~ Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward McCleary

6 DATE OF BIRTH (month, day, and year): May 6 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N. Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Andrew J. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah A. Knox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed OCT 28 1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 28-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929, to Oct 28, 1929, that I last saw her alive on Oct 28, 1929, and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis - 4 days.
Rheumatic heart disease - yrs.
Arteriosclerosis - yrs.
Hypertension - yrs.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jas. Bordley Jr. M. D.

10-28, 1929 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 10/31 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 28 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E. 50496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E. 50496

REGISTERED NO.

1—PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 27-B'G. WARD) Md

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Mary Fitzpatrick

(a) RESIDENCE NO. 721 Eutaw Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L Fitzpatrick

6 DATE OF BIRTH (month, day, and year): Sept 1859

7 AGE — Years: 70 | Months: 1 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home.

9 BIRTHPLACE (city or town) (State or country): Balto Co. Md

PARENTS

10 NAME OF FATHER: Patrick Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Minnich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John B Fitzpatrick

(Address) 721 Eutaw Place

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

OCT 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1929, to Oct 28, 1929

that I last saw her alive on Oct 28, 1929

and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V. Messina M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral — DATE OF BURIAL: 10/31/1929

20 UNDERTAKER: W. M. Cook — ADDRESS: 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E.50497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-001 E 50497

1—PLACE OF DEATH

REGISTERED NO. 27-447

CITY OF BALTIMORE: (No. 2905 Montebello Terrace ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Dippoldsmann, Jr.

(a) RESIDENCE NO. 2905 Montebello Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. 9 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1894

7 AGE Years	Months	Days 27	If LESS than 1 day, ...hrs. or ....min.
34	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electric Welder

(b) General nature of industry, business, or establishment in which employed (or employer) Novelty Boiler Works

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Dippoldsmann

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretha Kalbfleisch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Henry Dippoldsmann

(Address) 2905 Montebello Terrace

15 Filed OCT 28 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/25/29

17 I HEREBY CERTIFY, That I attended deceased from 10/22, 1929, to 10/25, 1929,

that I last saw h— alive on 10/25, 1929,

and that death occurred, on the date stated above, at 2 a., m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hyla W. Holley, M. D.

(Address) 5703 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Oct. 29, 1929
20 UNDERTAKER	ADDRESS
Harry H. Witzke	153 W. Lanvale St.

M. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E.50498

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50498

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 449 Lassan St. 12 Ward) 12-50

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa M Balmoni Connelley

(a) RESIDENCE NO. 449 Lassan St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John F Connelley

6 DATE OF BIRTH (month, day, and year): 10-9-61

7 AGE: Years 68 | Months 9 | Days 17 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant: John Connelley

(Address) 449 Lassan St

15 Filed ____, 19____ Registrar

OCT 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Disease

6 Years

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____ duration ____ yrs. ____ mos. ____ ds.

(Signed) John M Morrissey M. D.

(Coroner)

10/27/1929 (Address) 3422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial: Oct 29 1929

20 UNDERTAKER: Mary M Medfield ADDRESS: 501 E 22nd St

R. R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E5-0499

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

164 E5-0499

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2—FULL NAME Catherine Monaghan

(a) RESIDENCE NO. Preston + Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Monaghan

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 60 yrs				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Griffey

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Bridget Farmen

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston + Valley Sts

15 Filed ..... 19 ..... Registrar

OCT 29 1928 C. HUNTER SIMMS M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27th 1928

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1928, to Oct 27, 1928, that I last saw h..... alive on Oct 26, 28 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Lord, M. D.

10/28, 1928 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Oct 29, 1928
UNDERTAKER Elmer W. Conklin	ADDRESS 924 E. Eager St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E-50500 E50500 74-001 E50500

CERTIFICATE OF DEATH

REGISTERED NO. E-50500

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2729 St. Paul ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara May Woolford

(a) RESIDENCE NO. 2729 St. Paul ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) May 1, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	5	26 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER T. Thomas Woolford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Abbie Woolford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Custis W. Woolford
(Address) 3031 St. Paul St.

15 Filed OCT 29 1929, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Oct 27, 1929, that I last saw her alive on Oct. 26, 1929 and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cer. Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Delaney Thomas, M. D.

10/29, 1929 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct. 1929
20 UNDERTAKER John O. Mitchell & Sons	ADDRESS 1900 Eutaw Pl.

H. B. Mitchell

REMARK—THIS SPACE must be filled in. AGE should be stated in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50501

CERTIFICATE OF DEATH

x52 ✓

REGISTERED NO. E50501

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer Berry

(a) RESIDENCE NO. Whitehall Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7, 1915

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
14	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburgh Pa.

PARENTS

10 NAME OF FATHER John Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant [illegible] Lewis

(Address) 624 Eld. Mulberry st.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-25-29

17 I HEREBY CERTIFY, That I attended deceased from 1-22-, 19 29, to 10-25-, 19 29, that I last saw him alive on 10-25, 19 29 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Embolism Arterial
Acute Dilatation of
Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/20/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Jackson M. D.

10/25/29 (Address) 600 Darlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct. 28 29
20 UNDERTAKER Mrs. P. G. Elliott	ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 29 1929

Spec.—3-29-29—L. F. S.—500 Blks.

E50502

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E50502

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital ST., 15-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard Day.

(a) RESIDENCE NO. 1807 Kavanaugh ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col'd.	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 6/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	- 6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Eli Day.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Matilda Woodard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Matilda Day
(Address) 1807 Kavanaugh

15 Filed ..... 19 ..... Registrar

OCT 29 1929 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to Oct. 26, 1929.

that I last saw him alive on Oct. 26, 1929

and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Pathological findings —

(Signed) H. K. Faulconer, M. D.

Oct. 29, 1929 (Address) 100 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct. 30th 1929
20 UNDERTAKER	ADDRESS
Mrs. P. G. Elliott	Walbrook

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E50503 ✓ 24-001 E50503

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 10-14 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Cullen

(a) RESIDENCE NO. 1100 Harford Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ....., 19 R.U.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 192[illegible]

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 19 29, to Oct. 27, 19 29,

that I last saw him alive on Oct. 27, 19 29

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhagic nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy, lab.

(Signed) Marcus [illegible] M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct. 31 19 29
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elbert	1725 Eastern Ave.

OCT 29 1928 C. HAMMOND JR. M.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E50504

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E50504

REGISTERED NO. 1013

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1422 E. Monument St (WARD)

2—FULL NAME Ralph Wies

(a) RESIDENCE NO. 1422 E. Monument St WARD

(Usual place of abode)

Length of residence in city or town where death occurred City yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31st 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Emmett Wies

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret Aquilla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Emmett Wies

(Address) 1422 E. Monument St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28/29

17

I HEREBY CERTIFY, That I attended deceased from 10/14, 1929, to 10/28, 1929, that I last saw h alive on 10/28, 1929 and that death occurred, on the date stated above, at 1.25 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus due to Mal-Nutrition (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

Oct. 29 1929 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Oct 29 1929
20 UNDERTAKER Wm. R. A. Elliott	ADDRESS 1725 Eastlan Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEC 2 1929 HEALTH DEPT. BALTIMORE, MD.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50505

CERTIFICATE OF DEATH

90 ✓

E50505

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2323 Rosedale ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard T. Richardson

(a) RESIDENCE NO. 2323 Rosedale ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B. Richardson

6 DATE OF BIRTH (month, day, and year) Jan.4,1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	71	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Crane

(b) General nature of industry, business, or establishment in which employed (or employer): Operator

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thos.H.Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary B. Richardson

(Address): 2323 Rosedale St.

15 Filed OCT 29 1929 19 R H K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct.27,1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1929. to Oct 27 1929.

that I last saw h/m alive on Oct 27 1929

and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

from Treatory (duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H H Cushman, M. D.

19 Oct 28 1929 (Address) 3100 Hanford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Oct 29 1929
20 UNDERTAKER: John F. Denny	ADDRESS: 715 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E50506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E50506

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N Ann ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Ball

(a) RESIDENCE NO. 314 N Ann ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Chas Ball

6 DATE OF BIRTH (month, day, and year): April 1876

7 AGE — Years: 53 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Lucius Hewlett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Chas Ball Jr. son

(Address): 314 N Ann St

15 Filed ..... 19 .....

OCT 29 1929 C. HAMPSON JONES, P.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct, 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 19 24, to Oct 25, 19 24, that I last saw h.. alive on Oct 25, 19 24 and that death occurred, on the date stated above, at 5 30 A.m.

The CAUSE OF DEATH* was as follows:

Partial Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Toxemia Probably Carcinoma

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J Gosling M. D.

10/26 19 24 (Address) 1424 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alfmy and Oct 29 24

DATE OF BURIAL

20 UNDERTAKER: Mitchell Davis

ADDRESS: Elkton Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E50507

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50507

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3020 Mathews ST. 9th (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Hawkins

(a) RESIDENCE NO. 3020 Mathews ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Bessie Hawkins

6 DATE OF BIRTH (month, day, and year) Oct. 23 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fire door man

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berkleysville Md

PARENTS

10 NAME OF FATHER James Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co Pa

12 MAIDEN NAME OF MOTHER Lydia C. Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co Pa

14 Informant Elsie Christian

(Address) 625 E 30th St

15 Filed OCT 29 1929 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929, to Oct. 27, 1929, that I last saw him alive on Oct. 27, 1929 and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 19 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) S. Lee Maguire M.D.

10/28, 1929 (Address) 1906 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Oct 30th 1929
20 UNDERTAKER	ADDRESS
William Cook	1217 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stat. File No. E50508 S.—100 Bks.

E50508

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50508

100-002

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 813 S. Glover ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Raymond Szymanski

(a) RESIDENCE NO. 813 S Glover st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 5 "1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Leo Szymanski

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eva Glas Szymanski

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Leo Szymanski
(Address) 813 S Glover

15 Filed OCT 29 1929 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 "1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 21 19 29 to Oct 27 19 29,

that I last saw h[illegible] alive on Oct 27 19 29

and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

1 Meningitis - epidemic

2

3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebro spinal

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) [illegible], M. D.

Oct. 19 29 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	Oct. 29 1929
20 UNDERTAKER	ADDRESS
Stephen J. Fratkowski	1003 S. Haven

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E50509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001

E50509

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 W Cross St ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie Richardson

(a) RESIDENCE NO. 706 W. Cross St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John Richardson

6 DATE OF BIRTH (month, day, and year) July 9 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Robert Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Dornwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Mrs Mamie Richardson (Address) 706 W Cross St

15 Filed ..... 19 ..... Registrar

OCT 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1929, to Oct. 27, 1929, that I last saw her alive on Oct. 27, 1929 and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of -----

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) Thos. Kleiser, M. D.

(Address) 1224-1226 Hanover Street,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Oct 31 1929

20 UNDERTAKER Chas. H. Stevens — ADDRESS 130 2 Fort Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

E50510

CERTIFICATE OF DEATH

E50510

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: No. ST. 21-35 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Spencer

(a) RESIDENCE NO 1247 Hanbert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fotrew
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Baltimore City Hospitals
(Address)

15 Filed, 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27, 1929

17 I HEREBY CERTIFY That I attended deceased from Oct. 18, 1929, to Oct 27, 1929, that I last saw him alive on Oct 26, 1929, and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

Perforated gastric ulcer on greater curvature posteriorly

(duration) yrs. mos. 2d ds.

CONTRIBUTORY (Secondary) Pneumonia pantonalis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical & autopsy findings

(Signed) Harry Feldmann, M. D.

10/29/1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Oct 30 1929
20 UNDERTAKER	ADDRESS
Thos. L. Symons	107 E Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E.50511

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 E.50511

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 261

CITY OF BALTIMORE: (No. 928 S. Bouldin ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph G. Schreiber.

(a) RESIDENCE NO. 928 S. Bouldin ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Schreiber.

6 DATE OF BIRTH (month, day, and year) Feb. 22nd 1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 017

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Geo. Schreiber

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary M. Neuhaus

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Theresa Schreiber wife
(Address) 928 S. Bouldin St.

15 Filed ....., 19.... C. HAMPSON JONES M. D.
Registrar

OCT 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/29

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to Oct 27, 1929, that I last saw him alive on ....., 19...., and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Aneurism (thoracic)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Geo Heller, M. D.

10.29.29 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Oct 30 1929
20 UNDERTAKER Lilly & Jenkins Inc	ADDRESS 4033 Wash Blvd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E50512

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50512

88

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Smith

(a) RESIDENCE NO. 1118 N. Bay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Widow Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Smith

6 DATE OF BIRTH (month, day, and year) Aug. 4- 1884 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jas. Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ca

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed ....., 19 .... Registrar

OCT 29 1929 C. HAMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28/29

17 I HEREBY CERTIFY, That I attended deceased from 10/3, 1929, to 10/28, 1929, that I last saw h.. alive on 10/28, 1929 and that death occurred, on the date stated above, at 5-20 a.m.

The CAUSE OF DEATH* was as follows:

Emphysema right chest

(duration) Unknown

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 10/26/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. A. Luengstein M. D.

10/28 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westernport, Md.	Oct. 31 1929
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 E. Eager St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E50513 HEALTH DEPARTMENT—CITY OF BALTIMORE E50513

31

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 1024 S. Bouldin ST. 76-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antoinette M. Bocklage

(a) RESIDENCE NO. 1024 S. Bouldin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 4-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	27	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Medical Dept.

(c) Name of employer C. + P. Tel. Co.

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Frank J. H. Bocklage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Julia C. Portzl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Julia C. Bocklage

(Address) 1024 S. Bouldin St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27-1929

17 I HEREBY CERTIFY, That I attended deceased from January 2-, 1928, to October 27, 1929, that I last saw her alive on October 27" 1929 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 1 yrs 9 mos. 25 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isabel V. Tilney, M. D.

Oct. 28", 1929 (Address) 100. S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Oct 31 1929
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 E. Eager st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

C 29 1929 C. HAMPSON JONES

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50514

CERTIFICATE OF DEATH

90 E50514

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 Eastern Ave ST. 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T. Tracy

(a) RESIDENCE NO. 1911 Eastern Ave ST., 2 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Tracy

6 DATE OF BIRTH (month, day, and year) 23 Aug 1849

7 AGE	Years	Months	Days	If LESS than 1 day,....hrs. or....min.
	80	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Herbert Keyser, Daughter

(Address) 1911 Eastern Ave

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/29

17 I HEREBY CERTIFY, That I attended deceased (from Oct 20 29 to Oct 27 29, 19..)

that I last saw him alive on Oct 26, 1929

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

About (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Richard Slack, M. D.

Oct 29, 1929 (Address) 3201 E. Oliver

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Oct 31st 1929
20 UNDERTAKER	ADDRESS
Lilly & Giles Inc	4013 Wash Blvd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50515

CERTIFICATE OF DEATH

74-001

E50515

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4902 Cordelia Ave. ST. 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel L. Disney,

(a) RESIDENCE NO. 4902 Cordelia Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12, 1874,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dr. L. F. Barker

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry T. Disney

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Cornelia L. Audoun,

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mable E. Disney
(Address) 4902 Cordelia Ave.

15 Filed OCT 29 1929, 19 C. HEMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Oct 27, 1929,
that I last saw h[illegible] alive on Oct 26, 1929
and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain
Paralysis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) High Blood Pressure
Hardening of Arteries (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn, M. D.
10/29/1929 (Address) 3901 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Oct. 30 1929
20 UNDERTAKER	**ADDRESS**
Wm. E. Black	927 N. Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50516

CERTIFICATE OF DEATH

90 E50516

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 4-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Charles Belt

(a) RESIDENCE NO. 119 W. Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie Banks

6 DATE OF BIRTH (month, day, and year) July 31, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	74	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick County, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas H. Belt

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Boone

13 BIRTHPLACE OF MOTHER (city or town) Frederick County
(State or country) Md.

14 Informant Hospital Records
(Address)

15 Filed OCT 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28, 1929

17

I HEREBY CERTIFY, That I attended deceased from October 8, 1929, to October 28 1929.

that I last saw him alive on October 28, 1929

and that death occurred, on the date stated above, at 4:10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

~~Secondary~~ Anemia

Hemorrhage per bowel (cause undetermined)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic passive congestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 119 W. Lanvale St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. W. Gluck, M. D.

10/28. 1929 (Address) N. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Oct 30 1929
20 UNDERTAKER	ADDRESS
Henry Jenkins & Son Co	Richmond & Caldwell

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50517

CERTIFICATE OF DEATH

+ 90 E50517

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Pier No. 3 Pratt St. St. 4-6 Ward)

2-FULL NAME Francis E. Hayward

(a) RESIDENCE NO. Quincy, Mass St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred about 1 hr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)
Not obtainable

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	78	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Violin
(b) General nature of industry, business, or establishment in which employed (or employer) maker
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Quincy, Mass

PARENTS

10 NAME OF FATHER Eliphas Hayward

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Braintree, Mass.

12 MAIDEN NAME OF MOTHER
Charlotte Dwelle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Quincy, Mass

14 Informant John Hall,
(Address) Quincy, Mass

15 Filed OCT 29 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29. 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Val. Disease, heart

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. T. Riley Carney, M. D.

Oct. 29 19 29 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Acridental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Wollanton Cemetery, Quincy Mass	10/29 1929

20 UNDERTAKER H. W. Mears & Son ADDRESS 1050 N. Calvert St

Via American Railway Express—Consignee Hall, Quincy, Mass.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E50518

74-001

E50518

24-34

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1511 William St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Steven T. Rodgers.

(a) RESIDENCE NO. 1511 William St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah C. Rodgers.

6 DATE OF BIRTH (month, day, and year) May, 1860.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	69	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millworker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) A.A.Co Md.

PARENTS

10 NAME OF FATHER Steven Rodgers.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) A.A. Co Md.

12 MAIDEN NAME OF MOTHER Ellen Jenkins.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) A.A. Co. Md.

14 Informant Elsie Rodgers.

(Address) 1511 William St.

15 Filed ... 19... G. HAMPSON JONES, M. D. Registrar

1 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 19 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 14. 1929. to Oct 27. 1929

that I last saw h.. alive on Oct 27. 1929.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. L. Campbell M. D.

Oct 29 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Pk. Cem Date of Burial Oct 30 1929

20 UNDERTAKER Edward Evans ADDRESS 38 E. Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E50519

31 E50519

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2424 Arunah Ave. St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred B. White.

(a) RESIDENCE NO. 2424 Arunah Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 16, 1905.

7 AGE — Years: 24, Months: 1, Days: 11.

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady. 067

(b) General nature of industry, business, or establishment in which employed (or employer): Hochschild Kohn Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Wheeling W. Va.

PARENTS

10 NAME OF FATHER: William T. White.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Isabelle Barbour.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland.

14 Informant: Mrs. Anne J. Clonan

(Address): 2424 Arunah Ave.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

OCT 29 1929 Per Apth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 27-1929 19

17 I HEREBY CERTIFY, That I attended deceased from July, 19 29, to Oct 27, 19 29.

that I last saw h[illegible] alive on Oct 27, 19 29.

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Walter Morrison, M. D.

(Address) 1929 Eldonden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial: Oct 30 1929

20 UNDERTAKER: A. H. and Evans ADDRESS: 358 Fonda Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50520

CERTIFICATE OF DEATH.

9

E50520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Ramsay ST. 20-28 WARD)

2-FULL NAME Alice May Gelman.

(a) RESIDENCE No. 1906 Ramsay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 8. 1929

7 AGE — Years: — Months: 6 Days: 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Russell Gelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Alice Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Russell Gelman 1906 Ramsay St.

15 Filed OCT 29 1929, 19 — Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1929, to Oct 29, 1929, that I last saw h alive on Oct 24, 1929 and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. Hampson Jones, M. D.

Oct 29 1929 (Address) 1457 York Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Md Greenmount Cemetery — DATE OF BURIAL: Oct 30 1929

20 UNDERTAKER: Walter R. McNamee — ADDRESS: 4114 Fairfield Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should write mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E.50521 ✓ E.50521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23-31 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 185 W. Clement St. (ST.) (WARD)

2-FULL NAME Samuel A. Byus.

(a) RESIDENCE NO. 185 W. Clement St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 7 mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Mary Byus.

6 DATE OF BIRTH (month, day, and year) March 19, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Time keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Car & Found. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: John W. Byus.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Mary A. Anderson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Mary Byus. (wife)

(Address): 185 W. Clement St.

15 Filed ..., 19 ... Registrar ...

T 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28 19 29

17 I HEREBY CERTIFY, That I attended deceased from February 4th, 1928, to October 28th, 1929,

that I last saw him alive on October 27th. 1929

and that death occurred, on the date stated above, at 3.55 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Otto M. Rembrandt, M. D.

10/29 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	10 31 1929
20 UNDERTAKER	ADDRESS
E. J. Fanning Inc - 1886	E. Lafayette Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50522 E50522

CERTIFICATE OF DEATH

Fairfield 111-00

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1502 Brady Lane St. 4-5-26 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Heath

(a) RESIDENCE No. 1502 Brady Lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Heath

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 44 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: S. C.

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Memphis Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant (Address): Mary Walker

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M. D.

T 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct-27-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 15-, 1929, to Oct-27, 1929, that I last saw h[illegible] alive on Oct-27, 1929, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH was as follows: Gastric ulcer

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Coleman M. D.

(Address) 2037 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemetery	10/30 19
20 UNDERTAKER	ADDRESS
Robert Williams	1515 W Lanvale

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E59523 — 74-001 — E50523

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1008 S. Eutaw St., 11-24 WARD)

2-FULL NAME Caroline Williams

(a) RESIDENCE NO. 1008 S. Eutaw ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Williams

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Baltimore

PARENTS

10 NAME OF FATHER William Stokley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas Williams
(Address) 152 N. Bennitta St

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

OCT 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1929, to Oct 26, 1929, that I last saw h.. alive on Oct 26, 1929 and that death occurred, on the date stated above, at 11:05 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. 1 mos 17 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. Garland Schmidt, M. D.

Oct 29. 1929 (Address) 534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Oct 30 1929

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill

INFORMATION, WITH CLASSIFICATIONS AND TABULATIONS OF THIS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E50524

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-601

E50524

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3660 Falls Road ST.) (13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Burns.

(a) RESIDENCE NO. 3660 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. Tobitha Burns

6 DATE OF BIRTH (month, day, and year) July 27 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co (State or country)

PARENTS

10 NAME OF FATHER Wm. L. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Martha Lovell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant C. Tobitha Burns

(Address) 3660 Falls Road.

15 Filed OCT 30 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29-1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18- 1929, to Oct. 29- 1929.

that I last saw h[illegible] alive on Oct. 28- 1929.

and that death occurred, on the date stated above, at 1.07 A. m.

The CAUSE OF DEATH* was as follows:

Influenza, Broncho-Pneumonia.

(duration) yrs. mos. 12 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) [signature], M. D.

1930. 19[illegible] (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Oct 31 1929
20 UNDERTAKER	ADDRESS
Chenowith Son	3115 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50525

CERTIFICATE OF DEATH.

185 E50525

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Hanson Memorial Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Adessa Simpson

(a) RESIDENCE NO. 319-E-21-st St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank J. Owen

6 DATE OF BIRTH (month, day, and year) April 6-1891

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Alpha Photo Co

9 BIRTHPLACE (city or town)

(State or country) Alabama

PARENTS

10 NAME OF FATHER Albert E. Simpson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Alabama

12 MAIDEN NAME OF MOTHER Emma E. Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Tennessee

14 Informant Aleta Simpson

(Address) San Antonio Texas

15 Filed ..... 19.....

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Neck. Fell off a horse accidentally

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison M. D.

(Coroner)

10/28 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial Oct 30 29

20 UNDERTAKER Pitt-Cook ADDRESS 1211 St Paul

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 2-29-28 L. F. S. 500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50526

CERTIFICATE OF DEATH

84 ✓ E50526

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1418 Gorsuch Ave ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida May Tiler

(a) RESIDENCE NO. 1418 Gorsuch Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert A. Tiler

6 DATE OF BIRTH (month, day, and year) 3/30/1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chancey M Swift

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Moriah Fuller

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Mitchell Nicoll

(Address) 1418 Gorsuch Ave

15 Filed OCT 30 1929, 19 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10, 28, 29.

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 28, 1929, that I last saw h[illegible] alive on Oct 28, 1929 and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(duration) 6 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Haemaplegia Right sided

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas C. Clarke, M. D.

10/24/1929 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	10/31 1929

20 UNDERTAKER George J Ruth ADDRESS 1730 Eutaw Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E59527

CERTIFICATE OF DEATH

129 ✓ E59527

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N Broadway ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sue Hohman

(a) RESIDENCE NO. 711 N Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. G. Hohman

6 DATE OF BIRTH (month, day, and year) 2/4/1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 57

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Adolph Bluff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helena Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas G Hohman

(Address) 711 N Broadway

15 Filed OCT 30 1929 C. HAMILTON [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27-1929.

17

I HEREBY CERTIFY, That I attended deceased from August 25, 1929, to Oct 27, 1929, that I last saw h[illegible] alive on Oct 27 1929 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Interstitial Nephritis

Uremia (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas D Crum, M. D.

, 19 (Address) 727 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Oct 30th 1929

20 UNDERTAKER John Weis

ADDRESS 200 Albemarle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50528

CERTIFICATE OF DEATH

44

E50528

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene Sts. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence Kavanagh

(a) RESIDENCE NO. 2616 Guilford Ave ST.,

(Usual place of abode)

WARD

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Sue Shanahan Kavanagh

6 DATE OF BIRTH (month, day, and year) Feb 22-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	47	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Post Office

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Denis Kavanagh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sue S. Kavanagh

(Address) 2616 Guilford Ave.

15 Filed OCT 30 1929 19 C. HERBERT JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29-29

17 I HEREBY CERTIFY, That I attended deceased from 10-28-29, 19, to 10-29-29, 19, that I last saw h[illegible] alive on 10-29-29, 19 and that death occurred, on the date stated above, at 9.22 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Melanotic Sarcoma 3 mos. 5 ds.

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-28-29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Carl T. Limberth, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 11/2 1929

UNDERTAKER Chas. P. Maus & Son

ADDRESS 1120 N. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50529

CERTIFICATE OF DEATH. X 90 E50529

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Snattinger

(a) RESIDENCE NO. Reisterstown, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White Jewish

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Snattinger

6 DATE OF BIRTH (month, day, and year): Feb. 6, 1853

7 AGE: Years 76 Months 8 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: David Pfefferling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. S. Warner

(Address) 3500 Woodbrook Ave

15 Filed OCT 30 1929 By C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1929, to Oct. 29, 1929, that I last saw her alive on Oct. 29, 1929, and that death occurred, on the date stated above, at 4:40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, right

Broncho-pneumonia, terminal

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): arteriosclerosis; myocarditis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) BJ Ehrenfeld M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Gr.

DATE OF BURIAL: 10/31/1929

20 UNDERTAKER: David Sondheim

ADDRESS: 1702 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E50530

CERTIFICATE OF DEATH

101-001

E50530

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 919 N. Bradford ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Ludwig

(a) RESIDENCE NO. 919 N. Bradford ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced BUSBAND of (or) WIFE of Mary Ludwig

6 DATE OF BIRTH (month, day, and year) Mar. 31. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Weaver.

(b) General nature of industry, business, or establishment in which employed (or employer) Carpet Weaving

(c) Name of employer E Dratt.

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Rudolph Beranek

(Address) 2426 E. Monument Street

15 Filed OCT 30 1929, 19 Per C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 19 29, to Oct 29, 19 29, that I last saw him alive on Oct 29, 19 29, and that death occurred, on the date stated above, at 9 00 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia - 6 days.
myocarditis - ? ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. C. Sobkoff M. D.

10/30, 19 29 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Nov. 1 1929
20 UNDERTAKER	ADDRESS
August Paresk	2426 Ashland Ave

If DEATH is due to plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E59531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E59531

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1613 E. Monument St. 7-9 WARD)

2—FULL NAME John Scott—

(a) RESIDENCE NO. 1613 E. Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Scott

6 DATE OF BIRTH (month, day and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah Hill

(Address) 1613 E. Monument St

15 Filed OCT 30 1929 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/27/1929

17

I HEREBY CERTIFY, That I attended deceased from 10/21, 19 29, to 10/27, 19 29, that I last saw h. alive on 10/26, 19 29 and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy & Effusion

Compl. also

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. Young, M. D.

10/28 19 29 (Address) 1613 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	10-30 1929
20 UNDERTAKER	ADDRESS
Byron Knight	1218 E. Oldenry St

IMPORTANT—Occupation should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54 V

CERTIFICATE OF DEATH

E50532 REGISTERED NO. E50532

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hospital St. 10-15 WARD)

2—FULL NAME Sadie Watkins

(a) RESIDENCE NO. City County Jail ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colo	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	35	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (Prisoner)

(b) General nature of industry, business, or establishment in which employed (or employer) City Jail

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant James Lewis
(Address) 1021 Bevan St.

15 Filed ... 19 ... Registrar

OCT 30 1929 C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-7-29, to 10-26-29, that I last saw h[illegible] alive on Oct 26, 1929 and that death occurred, on the date stated above, at 10.05 A.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pellagra

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Jackson M. D.

Oct 26, 1929 (Address) 606 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt. Lowe	Oct 30 1929
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	848 W. Monty

For Directions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50533 ✓ 74-001 E50533

CERTIFICATE OF DEATH

1—PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 700 W. 40th st. ST 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth B. Pollard

(a) RESIDENCE NO. 1704 W. Hamburg ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 28-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Staum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Elizabeth Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Mrs. A. V. Hydesty

(Address) 609 Oak Ave

15 Filed OCT 30 1929 C. HAMPSON JONES, Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8- 1923 to Oct. 28- 1929.

that I last saw h W alive on Oct. 28- 1929.

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) uterine fibroid about

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no - Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Course,

(Signed) J. Boardman Briggs, M. D.

(Address) 212 S Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemt	Oct 31st 1929
20 UNDERTAKER	ADDRESS
Fortunato & De	1725 N Fulton Ave

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. Certificates may be refused registration unless properly classified. Use only plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

E50534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E50534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Md General Hosp

CITY OF BALTIMORE: (No. Howard & Madison ST. 16-27 WARD)

2-FULL NAME Mrs Annie F. West

(a) RESIDENCE NO. 1925 Harlem Av EST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, Married, Widowed, or ~~Divorced~~. (write the word): Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Lewis D West

6 DATE OF BIRTH (month, day, and year): April 14 1859

7 AGE — Years: 70 — Months: 6 — Days: 16 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Easton Md

PARENTS

10 NAME OF FATHER: Elam Frame

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Francis Glenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Hosp Record

15 Filed ... 19 ... Registrar

OCT 30 1929

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30 1929

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1928, to Oct 30, 1929, that I last saw him alive on Oct 30, 1929, and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uterus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Cachexia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 7/11/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. L. Reifschneider M. D.

Oct 30 1929 (Address) Md General Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Easton Talbot Co Md — DATE OF BURIAL: Nov 1st 1929

UNDERTAKER: Kertiam & Love — ADDRESS: 1723 W Lafayette Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—[illegible] Bks.

Relative [illegible] notified

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50535

CERTIFICATE OF DEATH

24-001

E50535

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Lockman

(a) RESIDENCE NO. 2908 Elliott ST., WARD
(Usual place of abode) wife
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Lockman

6 DATE OF BIRTH (month, day, and year) April 23, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer at incinerator

(b) General nature of industry, business, or establishment in which employed (or employer) Incinerator

(c) Name of employer City

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Lockman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Evard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Mary E. Lockman (Wife)
(Address) 2908 Elliott St.,

15 Filed OCT 30 1929, 19 [illegible] Registrar

C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-29.

17 I HEREBY CERTIFY, That I attended deceased from 10-24, 1929, to 10-27, 1929.

that I last saw him alive on 10-27, 1929.

and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At work - incinerator plant City of Balto.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W B Hendrix M. D.

, 19 (Address) St Joseph H. yard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery.	Oct. 30, 1929
20 UNDERTAKER Henry Sander & Sons Inc.	ADDRESS Baltimore St. & Broadway.

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50536 202 ✓ E50536

CERTIFICATE OF DEATH

1-PLACE OF DEATH Bethlehem Ship Building Co.

City of Baltimore: (No. 1101 Key Highway. St., 24-34 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold Francis Hatch.

(a) RESIDENCE NO. 1500 Riverside Ave. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married

5a If married, widowed or divorced, HUSBAND of Emma V.Hatch.

6 DATE OF BIRTH (month, day, and year) November 27,1896

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	32	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driller.
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Ship Building
(c) Name of employer Company.

9 BIRTHPLACE (city or town) .....
(State or country) Maine.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Do not know.

14 Informant Fletcher Scheckells.
(Address) 1500 Riverside Ave.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck on the head by a falling plank.

..... (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt M. D.

10/29, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Oct 31 1929
20 UNDERTAKER Joseph S Cook	ADDRESS 1003 W Fay St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50537

CERTIFICATE OF DEATH

181-004 E50537

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3504 Woodwork Ave St., 13-54 Ward)

2-FULL NAME Jacob Wilson

(a) RESIDENCE NO. 3504 Woodwork Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Wilson

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Builder
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Jack Wilson
(Address) 3504 Woodwork Ave.

15 Filed OCT 30 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, Autopsy or Inquiry.)
thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

CC Gas Poisoning. Auto.

(duration) yrs. mos. 1 hr.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. 1 da.

18 Where was disease contracted? Rear. 3504 — If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) H. G. Blades, M. D.

, 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodmen Circle, Mem. Mt. Carmel	10-30-1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E50538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓

E50538

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1743 Aveland Ave) (WARD) B

2—FULL NAME James Haywood Brown

(a) RESIDENCE NO. 1743 Aveland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 22. 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 668

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Matthews Co. Va.

12 MAIDEN NAME OF MOTHER Elizabeth Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kingston Co. Va.

14 Informant Elizabeth Brown

(Address) 1743 Aveland

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26. 29

17

I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1929, to Oct. 26, 1929,

that I last saw h[illegible] alive on Oct 26, 1929

and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema, Acute Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. + Autopsy.

(Signed) W. L. Bowy, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Oct. 30, 1929
20 UNDERTAKER	ADDRESS
Wm. R. A. Elliott	1715 Eastlund Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E50539

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E59539

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George E. Swift

(a) RESIDENCE NO. 1310 N. Broadway WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	white	married

5a If ~~married, widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or ~~WIFE~~ of) Alice I Swift

6 DATE OF BIRTH (month, day, and year) June 30-1884

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Luke Swift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Mary J. Keitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Alice E. Swift

(Address) 1310 N. Broadway

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-29

17 I HEREBY CERTIFY, That I attended deceased from 10-25, 1929, to 10-27, 1929, that I last saw h~~im~~ alive on 10-27, 1929, and that death occurred, on the date stated above, at 7 29 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 2 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) W W Hundley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Oct 31, 1929
20 UNDERTAKER Robt F. Turner	ADDRESS 1442 N. Broadway

OCT 30 1929

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. V. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50540 Mercy Hospital ✓ 131

CERTIFICATE OF DEATH

E50540

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard St., 4-1 WARD)

2—FULL NAME Leonard Murphy

(a) RESIDENCE NO. Ventnor Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 9th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) old

(c) Name of employer

9 BIRTHPLACE (city or town) Charles County (State or country) Md.

PARENTS

10 NAME OF FATHER George D. Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret D. Gifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George D. Murphy.

(Address) Ventnorville Md.

15 Filed OCT 30 1929 C. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30 1929

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to Oct 30, 1929.

that I last saw h.. alive on Oct 30, 1929

and that death occurred, on the date stated above, at 4.35 A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) yrs. 8 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) J Leyko M. D.

10/30, 1929 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairmount Park Md	Oct. 31 1929
20 UNDERTAKER	ADDRESS
George L. Schwartz	1101 Fulton Ave

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E50541 HEALTH DEPARTMENT—CITY OF BALTIMORE E50541

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2435 E. Preston ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Phoebus

(a) RESIDENCE NO. 2435 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Clendenon.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John F. Phoebus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Isabela Furman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Rose Durael (Address) 2435 E. Preston St

Filed OCT 30 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1929, to Oct. 27, 1929, that I last saw her alive on Oct. 27, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Schmidt, M. D.

Oct. 29 1929 (Address) 701 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Oct 31 1929
20 UNDERTAKER	ADDRESS
Geo M. Fuid & Son	811 W Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E59542 E59542

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 901 Ansquith Street ST., 10-14 WARD)

2-FULL NAME Sr. M. Ephrema Lapping

(a) RESIDENCE NO. Sisters of Notre Dame ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
70 Years		7 M. 6	15 days.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) Jacony Pa.
(State or country)

PARENTS

10 NAME OF FATHER Frank W. Lepping

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Frost

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sisters of Notre Dame
(Address)

15 Filed OCT 30 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 / 29 1929

17 I HEREBY CERTIFY, That I attended deceased from November 14, 1913 to October 29, 1929, that I last saw her alive on October 29, 1929, and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

Chronic Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) C. J. Kirby, M. D.

10 30, 1929 (Address) 110 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Md.

DATE OF BURIAL Oct 31 1929

20 UNDERTAKER Frank A. Fink

ADDRESS 415 N. Gay St

T 30 1929

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50543

CERTIFICATE OF DEATH

164 E50543

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Lynch

(a) RESIDENCE NO. Preston + Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER George Lynch

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Margaret " "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston + Valley Sts

15 Filed 30 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28th 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Oct 30, 1929, that I last saw h... alive on Oct 27, 1929, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Clemens Lutz, M. D.

10/30, 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Oct 31 1929

20 UNDERTAKER Dilatush Schofield

ADDRESS 914 Greenmount Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50544

CERTIFICATE OF DEATH

161-04 E50544

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Davis

(a) RESIDENCE NO. 2308 Whitelock Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 27 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1 hour	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Isaac Davis

11 BIRTHPLACE OF FATHER (city or town) Gfds Romania
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Mikaly

13 BIRTHPLACE OF MOTHER (city or town) Gfds Romania
(State or country)

14 Informant

(Address)

15 Filed OCT 30 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27 1929

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

that I last saw her alive on October 27, 1929

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Premature delivery (2 months) foetal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Not determined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eldred Roberts, M. D.

10/27, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS OCT 30 1929

Commissioner Health.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E50545

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E50545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4905 Harford Ave St. 27-4th Ward)

2-FULL NAME Ellen T. Nugent

(a) RESIDENCE NO. 4905 Harford Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About 59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown Nugent

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant John F. Toolan
(Address) 4905 Harford Ave

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

OCT 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

10/30/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 10/31 1929

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50546 E50546

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2816 Strathmore Ave ST. 27 WARD 44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hiltz

(a) RESIDENCE NO. 2816 Strathmore ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hiltz

6 DATE OF BIRTH (month, day, and year) Sept 8 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	77.	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Builder

(b) General nature of Industry, business, or establishment in which employed (or employer) Builder of Houses

(c) Name of employer Himself.

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John Hiltz

11 BIRTHPLACE OF FATHER (city or town) Hessen (State or country) Darmstadt. Hessen

12 MAIDEN NAME OF MOTHER Christina Stuff

13 BIRTHPLACE OF MOTHER (city or town) Hessen (State or country) Darmstadt. Hessen

14 Informant Howard Hiltz (Address)

15 Filed OCT 30 1929, 19 RKK Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13 1929 to October 29 1929, that I last saw him alive on October 29 1929, and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

July 13th 1929 to October 29. 1929

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Cancer of Rectum

(duration) One yrs. — mos. ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of Radium treatment

Was there an autopsy? No

What test confirmed diagnosis? Acidity

(Signed) George C. E. Vogler, M. D.

19 (Address) 3000 Hamilton ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov. 1 1929
20 UNDERTAKER	ADDRESS
Hughes & Jones Inc	424 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50547 E50547

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 Collins Ave ST. 70-21 (WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Alice B. Riddick.

(Residence in Baltimore: No. 303 Collins Ave, St.; 70 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, July 25, 1849 (Month) (Day) (Year)

7-AGE, 80 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER. Edward Carey

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Johanna Egan

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie L. Gannon

(Address) 303 Collins Ave.

15-

Filed 10 30 1929 C. HAMPSON JONES, M.D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10-28-, 1929. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10-24 1929, to 10-25 1929, that I saw h[illegible] alive on 10-27- 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

.....

Carcinoma of left breast

.....

..... (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

..... (Duration) yrs. mos. 5 ds.

(Signed) Thos. C. Blake M. D.

10-29-, 1929. (Address) 1 W. Mt. Vernon Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State yrs mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cemetery — DATE OF BURIAL, 10-31-, 1929

20-UNDERTAKER H. Brauning Son — ADDRESS 1136 Poplar Grove St

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50548

CERTIFICATE OF DEATH

202 ✓

E50548
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (En route to University Hospital 1929 Ward)

2-FULL NAME Robert C. McCollough

(a) RESIDENCE NO. 1923 E. Monument St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annabell McCollough

6 DATE OF BIRTH (month, day, and year) Sept 23 - 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Metal Worker
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer Balto. Tube Co.

9 BIRTHPLACE (city or town) .....
(State or country) Irland

PARENTS

10 NAME OF FATHER — McCollough

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Irland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Irland

14 Informant Mrs. A. McCollough
(Address) 1923 E. Monument St

15 Filed ..... 19.. .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30 — 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Crushing wound of Chest & abdomen. Accidental Death

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 430 Wicomico St
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene Feltz M. D.
10/30. 1929. (Address) 239 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cem — DATE OF BURIAL: Nov 2 1929

20 UNDERTAKER: Harry A. Witzke — ADDRESS: 1531 W. Lombard

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 30 1929 C. HAMPSON JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Blks.

B50549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 B50549

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 410 Font Hill Ave. ST., 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence J. Campbell

(a) RESIDENCE NO. 410 Font Hill Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 3 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary K. Campbell

6 DATE OF BIRTH (month, day, and year) July 9, 1881.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James Campbell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Eichelberger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mrs. Mary K. Campbell
(Address) 410 Font Hill Ave.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Oct 29, 1929.

that I last saw h.. alive on Oct. 29, 1929

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? no,

What test confirmed diagnosis? examination

(Signed) Chas. H. Mentzer, M. D.

10/30, 1929 (Address) 1730 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Oct 31 19 29
20 UNDERTAKER Harry H. Witzke	ADDRESS 153 N. Fremont Ave.

important. See instructions on back of certificates.

T 2 01829

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50550

CERTIFICATE OF DEATH

89 E 50550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2809 Eastern Ave., St., 12 Ward)

2-FULL NAME Mary E. Jenkins

(a) RESIDENCE NO. 2809 Eastern Ave., St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Jenkins

6 DATE OF BIRTH (month, day, and year) Jan. 30, 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	79	8	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick Von Bokern

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Harriet Hurley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant Mrs. Anna Zinkand
(Address) 2809 Eastern Ave.,

Filed ..... 19..... ..... M. D.
Registrar

3 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

10/30 1929 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lawn Cemetery	Oct 31st 1929
20 UNDERTAKER	ADDRESS
Lilly + Geiker Inc	403 S. Wolfe St

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50551

E 50551

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 5-9 Ward)

2-FULL NAME James Pinkett

(a) RESIDENCE NO. 934 N. Spring St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24/1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40	0	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Anne Arundel Co

PARENTS

10 NAME OF FATHER Joseph Pinkett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A.A.Co.

12 MAIDEN NAME OF MOTHER Ella Dockins

13 BIRTHPLACE OF MOTHER (city or town) A.A.Co
(State or country)

14 Informant Marcella Croner
(Address) Hamilton Md

15 Filed OCT 31 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

10/30/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy — DATE OF BURIAL Oct 31, 1929

20 UNDERTAKER J. H. Toadvine — ADDRESS 1027 Edmondson Ave

Do not write below this line

Oct should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50552

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50552

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1594

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 303 Lorraine ave ST. 12-50 WARD)

2—FULL NAME Wm Emerson Garrity

(a) RESIDENCE NO. 303 Lorraine ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 4th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	—	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Wm F Garrity

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mabel Lyons

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs Mabel M. Garrity

(Address) 303 Lorraine Ave

15 Filed ____, 19 ____ C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29th 1929

17 I HEREBY CERTIFY, That I attended deceased from (Birth) Oct 4, 1929, to Oct 29, 1929, that I last saw him alive on Oct 14, 1929 and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease (duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Congenital Malformation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical

(Signed) C. D. Emerson, M. D.

10-30 1929 (Address) 4936 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stony Chapel	Oct 31 1929

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Ellerslie

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50553 — 1-PLACE OF DEATH

REGISTERED NO. E 50553

City of BALTIMORE: (No. 711 St. Paul St. 11-15 Ward)

2-FULL NAME ~~711 St Paul~~ John D. Epes

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 711 St. Paul St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 68

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Sam F. Epes

11 BIRTHPLACE OF FATHER (city or town): Va

(State or country)

12 MAIDEN NAME OF MOTHER: Mary P. Williams

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: V. D. Mahon

(Address)

15 Filed....., 19.... C. HAMILTON JONES, M. D., Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Valv disease of heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

1929 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodstone, Va. Date of Burial: Oct. 31, 1929

20 UNDERTAKER: John O. Mitchell & Sons ADDRESS: 1900 Eutaw Pl.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50554

CERTIFICATE OF DEATH

E 50554

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospitals St., (Ward)

2-FULL NAME Gertrude E. Mitchell

(a) RESIDENCE NO. 3909 Falls Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 14, 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	44	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Evangelist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mass

PARENTS

10 NAME OF FATHER Mitchinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mitchinson

12 MAIDEN NAME OF MOTHER Edna Ballmon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mitchinson

14 Informant Balt City Hosp
(Address) Baltimore Md

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. E. Ladd, M. D.

19 (Address) 43 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	10/31 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 E Pratt St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50555

CERTIFICATE OF DEATH

E 50555

REGISTERED NO.

1—PLACE OF DEATH Balto Md

CITY OF BALTIMORE: (No. 1928 Griffis Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Lubinskie

(a) RESIDENCE NO. 1928 Griffis Ave ST., WARD Frackville Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Lubinskie

6 DATE OF BIRTH (month, day, and year) May 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Wm Taylor

(Address) 1928 Griffis Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from October 26, 1929, to October 30, 1929, that I last saw her alive on October 30, 1929 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Thomas, M. D.

Oct 30, 1929 (Address) 1901 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Lewis Frackville Pa	10/31 1929
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50556

170 ✓

E 50558

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 10 N. Linwood Ave St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles K. Lisieski

(a) RESIDENCE NO. 10 n. Linwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Lisiecki

6 DATE OF BIRTH (month, day, and year) Feb 10-1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Patrolman
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City
(c) Name of employer Police Dept.

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Lisiecki

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Wojciechowski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna Lisieckii
(Address) 10 N. Linwood Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage-Pistol shot wound of Chest-Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ill health

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination.

(Signed) J. Strohm, M. D.

Oct 30/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary.	10/31 1929

20 UNDERTAKER William Piaskowski ADDRESS 165 Eastern

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50557

CERTIFICATE OF DEATH

11-002

E 50557.

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Madison Ave St. 4-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie Ewell

(a) RESIDENCE NO. 1623 Madison Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Ewell

6 DATE OF BIRTH (month, day, and year) Dec 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Moses Ewell

(Address) 1623 Madison Ave

15 Filed ..... 19 ..... Registrar

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 28, 1929, that I last saw her alive on Oct 28, 1929, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Grippe

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Petticoin, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Oct 31 19 29
20 UNDERTAKER	ADDRESS
Samuel Ellenberg	518 N Bridle

Spec.—1-12-23—M&T—500 Blks.

E 50558

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50558

CERTIFICATE OF DEATH

× 31

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 6 E Hamilton ST. (or WARD) 11-7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Gordon Browne

(a) RESIDENCE NO. 6 E Hamilton ST. WARD Atlantic City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Balto, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Joseph Browne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant H Gryston Browne.
(Address) 1150 Argyle Ave

15 Filed OCT 31 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1929 to Oct 29, 1929, that I last saw h alive on Oct 27, 1929 and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) — yrs 5 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Atlantic City, N J.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Harry F. Brown, M. D.

10/30 1929 (Address) 1916 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Nov 1 19 29
20 UNDERTAKER Samuel J Hensley	ADDRESS 1 Eddie

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 50559

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 108 N. Madeira St., 6-10 Ward)

2-FULL NAME Mabel Brady

(a) RESIDENCE NO. 108 N. Madeira St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7/1913

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	16	0	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl D
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Brady

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Laura Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Henry Brady
(Address) Solley, Md.

15 Filed ..... 19.. L. H[illegible]ON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abortion (Accidental)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital Records

(Signed) [signature] M. D.

10/31/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Solley meth church cemetery — DATE OF BURIAL Nov 1 1929

20 UNDERTAKER Edward Bryan — ADDRESS 631 orleans st

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 31 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 50560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 50560

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 6-9 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Valentine

(a) RESIDENCE NO. 101 N. Bond ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Valentine

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer): 074

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Wm. Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Nancy ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records of

(Address): Balto. City Hosp.

15 Filed OCT 31 1929 H. J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 9, 19 29, to Oct. 27, 19 29

that I last saw h.im alive on Oct. 27, 19 29

and that death occurred, on the date stated above, at 9:25 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 1? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic, Endocarditis over 10

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Path. Exam. Sputum

(Signed) Marvin M. McLean, M. D.

(Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Oct 31 1929
20 UNDERTAKER: John D. Fahey Sons	ADDRESS: 1318 Light St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50561

E 50561

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 N. Eden ST. 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Heesh

(a) RESIDENCE NO. 1501 N. Eden ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 9 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Isabelle Heesh

6 DATE OF BIRTH (month, day, and year) Jany 27th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles A Heesh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ann E Hyland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant W R Heesh

(Address) 1501 N. Ensor St

15 Filed ..., 19... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Oct 29, 1929, that I last saw him alive on Oct 29, 1929 and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) death Lobar pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W G Davis, M. D.

Nov. 1929 (Address) 1509 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 1st 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1136 E Monument St

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50562

CERTIFICATE OF DEATH.

113 E 50562

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 811 S. Hanover St. 22-31 Ward)

2-FULL NAME Donald Leroy Thompson

(a) RESIDENCE NO. 811 S. Hanover St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 23 1929

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	—	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Roswell Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Fendall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Mary Fendall

(Address) 811 Hanover St

Filed 19 C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1929, to Oct 30, 1929, that I last saw him alive on Oct 29, 1929, and that death occurred, on the date stated above, at 3:4 m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Acute Gastro enteritis insufficiency

(duration) ___ yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O H Carroll, M. D.

10/30. 1929 (Address) 830 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct — Date of Burial Oct 31 1929

20 UNDERTAKER A. E. Brown & Son — ADDRESS 108 N. Monty

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50563

CERTIFICATE OF DEATH

49 ✓ E 50563

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 814 McKean Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rev John. J. Mayburry

(a) RESIDENCE NO. 814 McKean Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Male	white	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella. J. Mayburry

6 DATE OF BIRTH (month, day, and year) June 1 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER John Mayburry

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Harriet Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Ella J. Mayburry

(Address) 814 McKean Ave

15 Filed ... 19 ... Per ... Registrar

C. HAMILTON

NOV 3 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 7 1929, to Oct 30 1929, that I last saw h... alive on Oct 30 1929, and that death occurred, on the date stated above, at 10 00 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right testicle with metastasis in pelvis.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. Michel, M. D.

Oct 31. 1929 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	Nov 3 1929
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	2173 S. Pa.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50564

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50564

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 9-46 ST., WARD) REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Davison

(a) RESIDENCE NO. 2414 Montebello Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, (Widowed) or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER not Known

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs. Mary 2414 Montebello
(Address)

15 Filed OCT 31 1929 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30 '29

17 I HEREBY CERTIFY, That I attended deceased from 10-26, 1929, to 10-30, 1929, that I last saw her alive on 10-30, 1929 and that death occurred, on the date stated above, at 12-15 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiovascular disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 3+ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 10/30/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Lyons, M. D.

10/30, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov. 2 1929
20 UNDERTAKER	ADDRESS
Jos. J. Kerr	156 N. Luzerne

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50565

182

E 50565

REGISTRATION NO.

1-PLACE OF DEATH

City of Baltimore (No. Harbr. Inst. & Chester St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Franciszka Brzezinska

(a) RESIDENCE NO. 2050 Eastern St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
57.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Worked in
(b) General nature of industry, business, or establishment in which employed (or employer) Canning House.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland.

PARENTS

10 NAME OF FATHER Joe Stankiewicz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER
unk.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Bertha Krasewska.
(Address) 2050 Eastern Ave

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) I find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acc—
Drowning
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Exhausted
(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? — —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis?
Signed: H. J. Gladden M. D.
. 19 (Address) 1423 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Woods	1929
20 UNDERTAKER	ADDRESS
F W Ozazewski	1930 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

2 E 50566 (3 8 3)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 50566 REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Witkowski

(a) RESIDENCE NO. 725 S. Bethel ST. St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James

6 DATE OF BIRTH (month, day, and year) 9/21/96

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER John Setter

11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)

12 MAIDEN NAME OF MOTHER Ida Klimaski

13 BIRTHPLACE OF MOTHER (city or town) Ger —
(State or country)

14 Informant Records —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed DEC 3 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1929, to Oct 30, 1929

that I last saw h.e.r. alive on Oct 30, 1929

and that death occurred, on the date stated above, at 5-45 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, glioma, Cerebral

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Pathology

(Signed) Clarence E Gardner Jr, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Mor	12- 1929
20 UNDERTAKER	ADDRESS
F W Ozazewski	1930 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50567.

CERTIFICATE OF DEATH

45 E 50567.

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1314 Ashland Ave ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lilly Dunpin

(a) RESIDENCE NO. 1314 Ashland Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed.

3a If married, widowed, or divorced (or) WIFE of Chas H. Dunpin

6 DATE OF BIRTH (month, day, and year) appx 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Eliz Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mary Fletcher (daughter)

(Address) 1314 Ashland Ave.

15 Filed CTS 1 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1929, to Oct 28, 1929, that I last saw h[illegible] alive on Oct 27, 1929 and that death occurred, on the date stated above, at 6:10 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Gehring, M. D.

10/28 1929 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md.	Nov. 1st 1929
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1125 Ashland Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 50568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50568

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2135 Wilkens Ave ST. 20-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Moses Winer

(a) RESIDENCE NO. 2135 Wilkens Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bluma Winer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glazier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Elman Winer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Balto St

15 Filed 31 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-29

17 I HEREBY CERTIFY, That I attended deceased from 10/10/29, 19 to 10/30, 1929, that I last saw h[illegible] alive on 10/30, 1929 and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

10/30, 1929 (Address) 2033 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rock Road

DATE OF BURIAL 10/31, 1929

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

Spec.—8-24-14—M. & T.—2000 Bks.

E 50569 HEALTH DEPARTMENT—CITY OF BALTIMORE 1929 E 50569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1703 Warwick Av ST. 23-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fanny Adler

(Residence in Baltimore: No. 3 E. Hamburg St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid.

6-DATE OF BIRTH, Unknown (Month), ... (Day), 1 (Year)

7-AGE, 59 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): 537

9-BIRTHPLACE, (State or Country), Russia

Husband's name Bernard Adler

PARENTS.

10-NAME OF FATHER, Berel Miller

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Ballan

(Address) 1703 Warwick Av

15- Filed 3 1 1929 HAMPSON JOHNS, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct (Month) 30 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 1 1929, to Oct 30 1929, that I saw him alive on Oct 29 1929, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Asthenia Senilis

(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Apoplexy (cerebral)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. Kaden M. D.

10-31, 1929 (Address) 2306 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Washington Rd | DATE OF BURIAL, 10/31, 1929

20-UNDERTAKER Jack Lewis 1709 | ADDRESS E Balto St

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 50570

REGISTERED NO. E 50570

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Webster St ST. 24 33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Winckesley

(a) RESIDENCE NO. 1414 Webster St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Brickley

6 DATE OF BIRTH (month, day, and year) June 15 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.. Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad 873

(c) Name of employer B & O. R.R.

9 BIRTHPLACE (city or town) (State or country) Cecil Co Md

PARENTS

10 NAME OF FATHER Frank Winckesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cecil, Co, Md.

12 MAIDEN NAME OF MOTHER Rubicka Hanna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil

14 Informant Mrs Alice Winckesley

(Address) 1414 Webster St.

15 Filed OCT 31 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15 19 29 to Oct 29 19 29.

that I last saw h[illegible] alive on Oct 29 19 29.

and that death occurred, on the date stated above, at 4 05 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chr Valvular Endocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Schneyer, M. D.

19 (Address) 1337 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pennypack Furnace, Md.	Nov 2 1929
20 UNDERTAKER Chas L. Stevens	ADDRESS 1501 E Fort Ave.

Spec.—1-12-23—M&T—500 Bks.

E 50571

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50571

CERTIFICATE OF DEATH.

11-002

1-PLACE OF DEATH 3327 Caton Ave

CITY OF BALTIMORE: (No. 70-10 ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl Paul

(a) RESIDENCE NO. 3327 Caton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6 DATE OF BIRTH (month, day, and year) Sept. 11. 1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Car barn

(c) Name of employer United Railways.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Feick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Paul

(Address) 3327 Caton ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929 to Oct 30, 1929.

that I last saw him alive on Oct 30, 1929

and that death occurred, on the date stated above, at 2 9 m

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) F. T. Kyper, M. D.

, 19 (Address) 3321 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov. 1. 1929

20 UNDERTAKER C. W. Dell.

ADDRESS 3109 Fredk. Ave.

31 1929 C. HAMILTON JOHNS, M. D.

FILL in very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50572

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Local Baltimore Gen'l Hospital (Ward)

2—FULL NAME Lester Dean

(a) RESIDENCE NO. 1004 N. Bishop ST., Dallas, Texas WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/30/887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler

(b) General nature of industry, business, or establishment in which employed (or employer) Racetracks

(c) Name of employer Various

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER John Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Mattie Gipson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Mattie Dean

(Address) 1004 N. Bishop

15 Filed C. HAMPSON JONES, M. D. Registrar

1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30-29

17 I HEREBY CERTIFY, That I attended deceased from 10-17, 1929 to 10-30, 1929.

that I last saw him alive on 10-30, 1929

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Miliary Tuberculosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Joseph G Laukaitis M. D.

(Address) Local Baltimore General

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dallas Texas	10/31 1929
20 UNDERTAKER J. F. Bailey & Sons	ADDRESS 131 S Ervay St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50573

CERTIFICATE OF DEATH

E 50573

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Js Hosp St., 9-17 Ward)

2-FULL NAME Ralph M. Marsteller

(a) RESIDENCE NO. Glenburnie Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if nf foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3 1909

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
18	19	—	27	

8 OCCUPATION OF DECEASED
(a) Trade, professinn nr particular kind nf work Chauffeur
(b) General nature nf industry, business, or establishment in which employed (or employer) Don't know
(c) Name of employer Don't know

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thos C. Marsteller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Lucy Steele

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Thomas C Marsteller
(Address) Glenburnie Md

15 Filed 3 1 1929 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Rupture of Bladder (Gangrene) due to Paralysis due to fract of cervical Vertebra
Auto he was driving overturned
CONTRIBUTORY (Secondary) Crushing head Cervical Vertebrae 1 mo ago (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Ridgeville Md
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) D J Frame M. D.
10 By 1929 (Address) 2934 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Nov 3 1929
20 UNDERTAKER	ADDRESS
Thomas Elder	

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very necessary. Many deaths may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-16-29—L. F. S.—100 Bks.

Mrs Bode 1900 Md Ave
Ver 2977-J

E 50574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50574

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 1802 Barclay ST. 12-19 WARD)

2—FULL NAME Mary E Mc Causland

(a) RESIDENCE NO. 1802 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William J McCausland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Anne Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Agnes Small

(Address) 1802 Barclay St

15 Filed 3 1 1929, 19 C. HAMPSON JONES, M. D. Registrar.

Pct.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept-2nd, 1929, to Oct-31, 1929,

that I last saw h.. alive on Oct 31, 1929

and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 1 yrs. 3 mos. da.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	11/2 1929
20 UNDERTAKER	ADDRESS
W. Cook	1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50575

CERTIFICATE OF DEATH

181-004

E 50575

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3431 Liberty Heights Ave. 15-61 Ward)

2-FULL NAME Florence F Bailey

(a) RESIDENCE NO. 3431 Liberty Heights St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day and year) May 2 1898

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Indiana
(State or country)

PARENTS

10 NAME OF FATHER Paris Bailey

11 BIRTHPLACE OF FATHER (city Indiana
(State or country)

12 MAIDEN NAME OF MOTHER Lula Sargent

13 BIRTHPLACE OF MOTHER Indiana
(State or country)

14 Informant Paris Bailey
(Address) 3601 Liberty Heights Ave

15 Filed 19 C. HAMPSON JONES, M.D. Registrar
Per A.K.W.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 30th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
(Asphyxia Carbon Monoxide Gas)
(duration) Sudden

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted? 3431 Liberty Heights
If not at place of death:

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Th Oct 30th/29 H. Leland Taylor, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 1st 1929
20 UNDERTAKER	**ADDRESS**
Wm Cook	1217 St Paul St

NOV 1 1929

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50576

1—PLACE OF DEATH Baltimore City Hospitals (C. H.) REGISTERED NO. 8-13

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Maurer

(a) RESIDENCE NO. 2016 E. Chast st. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Maurer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Wise

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 3 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25 29, 19..., to Oct. 30 29, 19...,

that I last saw her alive on Oct. 30 29, 19...

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy with effusion

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Hinrichs M. D.

10-31, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL Nov 2nd 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

Cor.—10-10-29—A Co.—100 Bks.

E 50577

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-103 ✓ E 50577

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No.) Union Mem. Hosp St. 27-48 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida May Brooks

(a) RESIDENCE NO. 5224 Crowson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	Wh.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sidney W Brooks

6 DATE OF BIRTH (month, day, and year) May 5 — 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or min.
	56	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Don't Know
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Mr. Brooks
(Address) 607 N Calhoun Ave

15 Filed ..... 19.....

OCT 31 1929 C. HAMPSON JONES, JR. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull. Struck & knocked down by auto —

(duration) yrs. mos. ds.

CONTRIBUTORY Fract mandible
(Secondary) Traumatic Shock
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Homeland & Roadway

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Frame M. D.

10/31 1929 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov. 1, 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St.

May be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH E 50578 — REGISTERED NO. 74 E 50578

CITY OF BALTIMORE: (No. 738 N. Carey ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nelson Sims

(a) RESIDENCE NO. 738 N. Carey ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Gen

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ida Campbell

(Address) 738 N Carey St

15 Filed NOV 1 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1929, to Oct 29, 1929, that I last saw him alive on Oct 29, 1929, and that death occurred, on the date stated above, at 2.40 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia Arteriosclerosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Hinton M. D.

Oct 31 1929 (Address) 712 S. Bond Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National	Nov 1 1929
20 UNDERTAKER	ADDRESS
Jno. W. Toadvine	1027 Druid Hill

Be sure that DISEASE causing death is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50579

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50579

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary St., 6-9 Ward)

2-FULL NAME Annie R. Hendren

(a) RESIDENCE NO. Country Club Road, Winston-Salem, N.C. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. M. Hendren

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 07
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Ruffin, N.C.

PARENTS

10 NAME OF FATHER T. L. Rawley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ruffin, N.C.

12 MAIDEN NAME OF MOTHER Sallie Lindsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ruffin, N.C.

14 Informant Wm. M. Hendren (Husband)
(Address) Winston-Salem, N.C.

15 Filed NOV 1 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Epidemic Encephalitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Respiratory Failure-Broncho-pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

10/31/29 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winston-Salem, N.C	11/1/ 1929
20 UNDERTAKER	ADDRESS
Henry W. Meursdon	805 N. Calvert

S.P.R. and Southern R.R. Escort Mr. William M. Hendren.

Spec.—2-25-28—L. F. S.—500 Blks.

E 50580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50580

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3714 Foster ave ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise E. Goeller

(a) RESIDENCE NO. 3714 Foster ave ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam E. Goeller

6 DATE OF BIRTH (month, day, and year) Nov 22nd 1887

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
41	11	8 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August Heiland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Lehr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Adam E. Goeller

(Address) 3714 Foster ave

15 Filed ....., 19.... [illegible] Registrar

[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 1 29 to Oct 27 29

that I last saw h alive on Oct 27 1929

and that death occurred, on the date stated above, at 10.40 p. m.

The CAUSE OF DEATH was as follows:

Myocardial degeneration
(Primary)

(duration) yrs. 2 mos. d

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. H. Burgess M. D.

10 W 29 (Address) 20 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	11/2 1929.
20 UNDERTAKER Lilly + Zeiler Inc	ADDRESS 408 S. Wolfe St

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50581

185 ✓

CERTIFICATE OF DEATH

E 50581

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp ST. 15-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Lowra Boyds

(a) RESIDENCE NO. 2700 Barlyn Ave. Roslyn Apts Roslyn Baltimore apts Balto and ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 3, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Boyds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgetown Md

12 MAIDEN NAME OF MOTHER Malvina Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Olivia Pearson

(Address) Baltimore Roslyn apts

15 Filed ..... 19.. Registrar C. HAMPSON JONES, M. D.

V t 1928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/16/29, 19..., to 10/29/29, 19...,

that I last saw h.. alive on 10/29/29, 19...

and that death occurred, on the date stated above, at 11 52 P.M.

The CAUSE OF DEATH* was as follows:

Fractured Femur (Rt) ✓ DEV

Dr. J. J. Morrissey Coroner

(duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema (duration) ... yrs. ... mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Roslyn Apts.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) Samuel McC Linthicum, M. D.

Oct 31 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Nov 1 1929
20 UNDERTAKER	ADDRESS
Chas O Mitchell & Son	1900 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Blks.

E 50582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 50582

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 807 E. 33 ST., 9-46 WARD)

2—FULL NAME John J. E. Burkhardt

(a) RESIDENCE NO. 807 E. 33 ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura G. Burkhardt

6 DATE OF BIRTH (month, day, and year) June 6 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Guard. R. R. S.

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md,

PARENTS

10 NAME OF FATHER Jacob Burkhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rhoda Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pound

14 Informant Howard E. Burkhardt

(Address) 26 Newport St Claremont

15 Filed ..... 19 .....

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 16 19 29 to Oct 29 19 29

that I last saw him alive on Oct 1 9 19 29

and that death occurred, on the date stated above, at 12:15 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Chronic Nephritis

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. W. Bishop, M. D.

Oct 30 1929 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Nov. 1 1929
20 UNDERTAKER	ADDRESS
John D. Mitchell Sons	Eutaw Pl.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 50583

CERTIFICATE OF DEATH

24001

REGISTERED NO. E 50583

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6628 Harford Road ST., 27-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Mortimer Gray

(a) RESIDENCE NO. 6628 Harford Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella L Gray

6 DATE OF BIRTH (month, day, and year) Aug 19 ~~1882~~

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
47	~~47~~	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER Wm J. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Estella L Gray

(Address) 6628 Harford Road

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1921, to Oct 30, 1929, that I last saw h~~im~~ alive on Oct 30, 1929 and that death occurred, on the date stated above, at 9.30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr. C. Gray M. D.

10/31, 1929 (Address) 6631 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Nov 4 1929

20 UNDERTAKER Wm J Tickner & Sons

ADDRESS Govans

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50584

CERTIFICATE OF DEATH

49 ✓ E 50584

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2002 Westwood Ave ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachel Sherman

(a) RESIDENCE NO. 2002 Westwood Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rubin Sherman

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 54 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Simon Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Esther —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: J. Lewis

(Address): 1429 Baltz. St.

15 Filed ..., 19... HAMPSON [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 1-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept., 1928, to Oct. 31, 1929, that I last saw h[illegible] alive on Oct. 31, 1929, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma with metastasis.

about (duration) 1 yr. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes. Date of about 1 yr ago.

Was there an autopsy? no

What test confirmed diagnosis? X-Ray & physical.

(Signed) Nathan H. Shpritz M. D.

. 19 (Address) 2318 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: Nov 1st 19 29

20 UNDERTAKER: Jack Levis

ADDRESS: 1429 E Balt St

Spec.—1-12-23—M&T—500 Blks.

Chulinski

HEALTH DEPARTMENT—CITY OF BALTIMORE

50585

CERTIFICATE OF DEATH

33 E 50585

1-PLACE OF DEATH West Baltimore General

CITY OF BALTIMORE: (No. 5-9 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Mike Chulinski.

(a) RESIDENCE No. 213 S. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C

6 DATE OF BIRTH (month, day, and year) Nov. 15 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Walter Chulinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Zagorski

(Address) Central Dairy Md

15 Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1929. to Oct. 31 1929

that I last saw living alive on Oct. 31 1929

and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Generalized Tuberculosis (Intestinal - Renal.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/11 - 9/27 10/24 - 10/25

Was there an autopsy? No.

What test confirmed diagnosis? Clinical - O. P.

(Signed) J. Calogna, M. D.

10/31 1929 (Address) West Balto. General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Cross C. C. Nov 2 1929

20 UNDERTAKER — ADDRESS

Hurst-Brack & Co 1911 Eutaw Pl.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50586 — 129 — E 50586

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2825 N Calvert St. Ward) 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Cushing Pacelli

(a) RESIDENCE NO. 2825 N Calvert St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Louis Adam Pacelli

6 DATE OF BIRTH (month, day, and year): 2-15-1878

7 AGE: Years 51 — Months 8 — Days 16 — IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home — 29

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry M Cushing

11 BIRTHPLACE OF FATHER (City or town): Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER: Tolson

13 BIRTHPLACE OF MOTHER (city or town): Maryland

(State or country)

14 Informant: Mrs B. E. Calhoun

(Address) 2825 N. Calvert St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-31-1929

17 I HEREBY CERTIFY, That I attended deceased from 8-28-, 1929, to 10-30-, 1929, that I last saw h[illegible] alive on 10-30-, 1929, and that death occurred, on the date stated above, at 11 30 A. M.

The CAUSE OF DEATH* was as follows: Intercostal Neuritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood & Urine Analysis

(Signed) Wm A. Duvall M. D.

(Address) 3523 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial Nov 2nd 1929

20 UNDERTAKER: C Carson Kennard — ADDRESS 423 W. Lafayette Ave

. very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50587

CERTIFICATE OF DEATH.

101-001 E 50587

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 W Lanvale ST. 16-22 WARD)

2-FULL NAME Edward Larkins

(a) RESIDENCE NO. 1514 W Lanvale ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26-29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John W Larkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elva E. Woolford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John W Larkins

(Address) 1514 W Lanvale

15 Filed NOV 1 1929 Registrar

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/26, 1929, to 10/31, 1929, that I last saw him alive on 10/31, 1929 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ben Keith, M. D.

(Address) 134 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Nov 2 1929

20 UNDERTAKER Chas. H. Chase Son — ADDRESS 1400 Mosher

Spec.—2-29-28—L. F. S.—500 Bks.

E 50588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 50588

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hospitals ST. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Keim

(a) RESIDENCE NO. 4317 Park Heights ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 8 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Keim

6 DATE OF BIRTH (month, day, and year) Feb 6th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) 084

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Keim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Dorothy Yoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

Filed NOV 1 1929, 19 HARRY JONES, [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30/29

17 I HEREBY CERTIFY, That I attended deceased from 8/10, 19 25, to 10/30, 19 29, that I last saw him alive on 10/30, 19 29 and that death occurred, on the date stated above, at 4 40 P. m.

The CAUSE OF DEATH* was as follows:

Perforating ulcer of both feet

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Pumphrey, M. D.

10/31, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL Nov. 1 1929

20 UNDERTAKER Chas. E. Franck

ADDRESS 502 Madison Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50589

CERTIFICATE OF DEATH

1001 16

E 50589

1—PLACE OF DEATH Woman's Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 12-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stella Hughes.

(a) RESIDENCE NO. 2714 Calbert ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Howard A. Hughes

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Stella Mason

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Baltimore Md.

14 Informant Howard A. Hughes
(Address) 2714 Calbert.

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929. to Oct 30, 1929.

that I last saw her alive on Oct 30, 1929

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 months)

Cause not known.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rudolph Schaeffer, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carnegie Laboratory	19
20 UNDERTAKER ✓	ADDRESS

Spec.—2-20-28—L. F. S.—500 Bks.

E 50590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

79 ✓ E 50590

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E. Graham

(a) RESIDENCE NO. 209 N. Madeira ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a ~~If married,~~ widowed, ~~or divorced~~
HUSBAND of ~~(or) WIFE of~~ Georgianna Graham

6 DATE OF BIRTH (month, day, and year) Unknown 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 30

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 8 years

(c) Name of employer Ritz and Kuter.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jno. Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Jane Wickes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed 1929 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/30/29

17 I HEREBY CERTIFY, That I attended deceased from 10/5 , 1929, to 10/30 , 1929

that I last saw h~~im~~ alive on 10/30 , 1929

and that death occurred, on the date stated above, at 9 40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma prostate gland

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin , M. D.

10/30, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov. 1 1929
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	Baltimore St & Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50591

CERTIFICATE OF DEATH.

E 50591

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3925 Wilkens ave ST. 25-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Walker Leydecker

(a) RESIDENCE No. 3925 Wilkens ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Fifty mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 - 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Philip Leydecker

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Ethel M. Briggs

13 BIRTHPLACE OF MOTHER (city or town) Toronto
(State or country) Canada

14 Informant Philip Leydecker
(Address) 3925 Wilkens ave

FILED NOV 1 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Oct 31, 1929, that I last saw him alive on Oct 31, 1929, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever —
Streptococcus Angina

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis
Pulmonary Oedema
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C Nuzum M. D.

(Address) 2658 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL Nov. 1st 1929

20 UNDERTAKER George L. Schwartz — ADDRESS 2101 Fulk. Ave

IMPORTANT: See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. E 50592

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1373 N. Gilmor St. (ST.) 15-22 (WARD)

2-FULL NAME Nettie Murdock Johnston

(a) RESIDENCE No. 1373 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Johnston

6 DATE OF BIRTH (month, day, and year) 3-12-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	57	7	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella Hamm

(Address) 1373 N Gilmor St

15 Filed NOV 1 1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31- 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-3-, 1929, to 10-31-, 1929, that I last saw h alive on 10-31-, 1929, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George C Page, M. D.

, 19 (Address) 1816 N. Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Nov 2nd 1929

20 UNDERTAKER — ADDRESS

IMPORTANT—See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 50593

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50593

CERTIFICATE OF DEATH.

62

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 Pearl St. St. 1725 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Millard

(a) Residence No. 415 Pearl St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) October 14, 1929

7-AGE. ....yrs. ....mos. 16 ....ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, Md (State or Country),

PARENTS.

10-NAME OF FATHER, LeRoy Griffin

11-BIRTHPLACE OF FATHER (city or town) Tuskeegee (State or Country).

12-MAIDEN NAME OF MOTHER, Alice Millard

13-BIRTHPLACE OF MOTHER (city or town) Balto., Md (State or Country).

14- (Informant) Alice Millard

(Address) 415 Pearl St

15- Filed ..... 1929 HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) October 30, 1929

17- I HEREBY CERTIFY, That I attended deceased from October 14 1929 to October 30 1929

that I last saw h[illegible] alive on October 30 1929

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Intoxication

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Enlarged Thymus

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M D

10/31/29 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	11-1 1929
20-UNDERTAKER.	ADDRESS
Edward Conboy	962 [illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50594

90 E 50594

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp. St., 11-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Murray

(a) RESIDENCE NO. unknown St., 1846 Penna Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Coroner How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	58	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Laura Bennett
(Address)

15 Filed NOV 4 1929 HAMILTON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cy Lawshon

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Jos Custer States, M. D.

(Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carburn Cem	11-1-1929

20 UNDERTAKER Daniel Easton ADDRESS 96 Pa ave

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

E 50595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 ✓E 50595

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp 26-38 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beulah Wilson

(a) RESIDENCE NO 6201 Debelius ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Femal	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	7	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Ernest Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ga.

12 MAIDEN NAME OF MOTHER Beulah Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ga

14 Informant Ernest Wilson
(Address) 6201 Debelius Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns over face & body
(Clothes caught fire while using coal oil to start fire in stove.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Bonn, M. D.

11/1/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	11-1 1929
20 UNDERTAKER Daniel Easton	ADDRESS 836 Penna

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50596

CERTIFICATE OF DEATH

31 E 50596

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 620 No Carey ST. 16-23 WARD)

2—FULL NAME Dorothea J. McLaughlin

(a) RESIDENCE NO. 620 No Carey ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanley McLaughlin

6 DATE OF BIRTH (month, day, and year) 3/23/06.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Ochs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Elizabeth Wills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Elizabeth C Ochs

(Address) 620 No Carey St

15 Filed 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30-1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to Oct 30, 1929, that I last saw her alive on Oct 30, 1929 and that death occurred, on the date stated above, at 9.25 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs.

..... (duration) 1 yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Tuberculosis intestine

..... (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam. etc.

(Signed) C. W. Hoffman, M. D.

, 19 (Address) 8 East Read St. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	11/2. 1929
20 UNDERTAKER [illegible]	ADDRESS 113 Poplar Grove St
113 Poplar Grove St.	

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50597

CERTIFICATE OF DEATH

90 E 50597

REGISTERED NO.

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Merrill

(a) RESIDENCE NO. 520 Dover St. ST., 22-30 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? DHO

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Edward Merrill

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER Lizzie ? 10-31

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Records ?

(Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-29

17 I HEREBY CERTIFY, That I attended deceased from 7-6, 1928, to 10-31, 1929, that I last saw him alive on 10-31, 1929, and that death occurred, on the date stated above, at 5 00 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

..... (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin. & P.E.

(Signed) Marvin M. Mc Lean, M. D.

(Address) BALTIMORE CITY HOSPITALS 10-31, 1929

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Nov 4 1929
20 UNDERTAKER	ADDRESS
John H Tradwell	1022 Druid Hill

Spec.—8-16-29—L. F. S.—100 Bks.

E 50598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 50598

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 122 N. Mount ST., 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Calvin Parker

(a) RESIDENCE NO. 122 N. Mount ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colo	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Parker

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 0-10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Calvin Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Susan Parker

(Address) 122 N. Mount

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Oct 29, 1929, that I last saw h... alive on Oct 24, 1929 and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colon

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T J Norwood, M. D.

Oct 31/29 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov 1, 1929
20 UNDERTAKER	ADDRESS
Mrs Kate R Williams	3227 Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50599

CERTIFICATE OF DEATH

74001 ✓ E 50599

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 N. Caroline ST. 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriett R. Armstrong

(a) RESIDENCE NO. 1816 N. Caroline ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. James. E. Armstrong

6 DATE OF BIRTH (month, day, and year): Aug. 25 1850

7 AGE: Years 79 | Months 2 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George P. Winchester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. Clarence H. Armstrong

(Address) 4722 Gwynn Road

15 Filed 1929. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): NOV 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 , 1929 to Nov 1 , 1929 that I last saw h[illegible] alive on Oct 31 , 1929. and that death occurred, on the date stated above, at 1.20 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis (duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William R. Dandridge M. D.

(Address) 801 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Nov. 4 1929
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons, Inc.	1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 ✓

E 50600 — REGISTERED NO. E 50600

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1927 T. Lee St., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Everett

(a) RESIDENCE NO. 1927 T. Lee ST., 2 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 1 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William T. Everett.

6 DATE OF BIRTH (month, day, and year) Sept. 12 1873 ~~1873~~

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56.	1	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Prins.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. Paul.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William T. Everett
(Address) 1927 T. Lee St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4th 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929 to Nov 4 1929.

that I last saw her alive on Oct 31- 1929

and that death occurred, on the date stated above, at 2 15 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Clinical Findings

What test confirmed diagnosis?

(Signed) J. C. Clades M. D.

(Address) J. C. Clades

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov 7 1929
20 UNDERTAKER Lilly & Geiss Inc	ADDRESS 1032 W Fayette St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50601 — 1—PLACE OF DEATH — REGISTERED NO. E 50601

129

9-47

CITY OF BALTIMORE: (No. 3951 Greenmount Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Whorton Wilson.

(a) RESIDENCE NO. 3951 Greenmount Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Cecilia Duke Wilson.

6 DATE OF BIRTH (month, day, and year) July 6 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Postmaster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. P.O. Dept.

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs. Geo. T. Donnely

(Address) 3951 Greenmount Ave.

15 Filed 11 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Oct 31-29, 19 29, that I last saw h[illegible] alive on Oct 31, 19 29 and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Ch. Ds. Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. W. Bostick, M. D.

Nov 1, 1929 (Address) 501 Schroeder Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Govans	11/2/29
20 UNDERTAKER C. Vernon Lemmon.	ADDRESS 4513 Park Heights Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

50602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 50602

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4005 Woodlea ave ST. Rayon 47-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME IDA MAY FISHER GRAY

(a) RESIDENCE NO. 4005 Woodlea ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert a. Gray

6 DATE OF BIRTH (month, day, and year): Jan. 27-1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph I. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Md.

12 MAIDEN NAME OF MOTHER: Mary E. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Robert a. Gray

(Address) 4005 Woodlea ave

15 Filed ....., 19.... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 31st 1929

17 I HEREBY CERTIFY, That I attended deceased from July 17th, 1929, to October 30th, 1929, that I last saw h... alive on October 26, 1929 and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pulmonary Tuberculosis
Tuberculous Enteritis

(duration) 5 yrs. approximately mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Applicable

Did an operation precede death? No Date of Not Applicable

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Thomas Conrad Wolf M. D.

, 19 (Address) 1032 E. 36th St., Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: Nov 2 1929

20 UNDERTAKER: George W. Zirkler

ADDRESS: 1737 E. Eager st.

Spec.—2-29-28—L. F. S.—500 Bks.

50663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50663

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 342 S Stricker ST., WARD)

2—FULL NAME Florence M Ganley

(a) RESIDENCE NO. 342 S Stricker ST., 19-25 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Philip Ganley

6 DATE OF BIRTH (month, day, and year) July 15, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	63	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Theresa Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm A. Ganley

(Address) 342 S Stricker St.

Filed NOV 1 1929, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 23, 1929 to October 30, 1929, that I last saw her alive on October 29, 1929 and that death occurred, on the date stated above, at 5 07 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs — mos. 2 ds.

CONTRIBUTORY (Secondary) Interstitial nephritis and elephantiasis (duration) over 2 yrs — mos — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical tests

(Signed) Henry C Ohle, M. D.

10-31, 1929 (Address) 1203 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catherdal Cemetery	11/2 1929
20 UNDERTAKER	ADDRESS
Geo. A Farley	1800 W. Fayette St.

Cor.—10-10-29—A Co.—100 Bks.

E 50663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-001 E 50664

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. W. M. R. R. & Monroe St. Ward)

2-FULL NAME Martin P. Geraghty.

(a) RESIDENCE NO. 2026 E. North St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if nf foreign birth? yrs. mns. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE nf Helen Mac Geraghty

6 DATE OF BIRTH (month, day, and year) May 15-1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29	5	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto A. & T. Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Timothy Geraghty

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Harkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Helen Geraghty
(Address) 2026 E. North Ave

15 Filed ..... 19..... C. HAMPSON JONES, M. D.
1929 A. C. H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31st 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

R. R. Accident
Fractured Skull &
Fractured Right & Left
Tibia & Fibula (duration) Instant
CONTRIBUTORY (Secondary) (Struck by train)
(duration) hrs. mos. ds.

18 Where was disease contracted? If not at place of death? W. M. R. R. & Monroe.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Oct 31st 1929 F. C. Klunk M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	11/4 1929

20 UNDERTAKER Chas. E. Krause & Son ADDRESS 1180 W. Pratt & Royal Ave

Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 50605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 50605

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2008 Guilford Ave. Ward 14)

2-FULL NAME Ella V. Pate

(a) RESIDENCE NO. 2008 Guilford Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nathaniel D. Pate

6 DATE OF BIRTH (month, day, and year): Jan 28- 1877

7 AGE: Years 52; Months 10; Days 3; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town): .....

(State or country): Md.

PARENTS

10 NAME OF FATHER: James Agnew

11 BIRTHPLACE OF FATHER (city or town): .....

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Burns

13 BIRTHPLACE OF MOTHER (city or town): .....

(State or country): Md.

14 Informant: Mildred L. Ford

(Address) 423 E. 25th St.

15 Filed ..... 19 C. HAMPSON JONES, M. D., Registrar

LAON PAT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): October 31st 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 28 1929 to Oct 30, 1929, that I last saw h[illegible] alive on Oct 30, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hugh Forsythe, M. D.

10/31, 1929 (Address) 423 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial 11/4 1929

20 UNDERTAKER: Chas. P. Maus & Son — ADDRESS 1810 W. Mt. Royal Ave.

Key important. See instructions on back of Certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50666

CERTIFICATE OF DEATH

188-103 ✓ E 50666

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St. H-7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Doyle

(a) RESIDENCE NO. 154 N. Gay St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs or min.
40?				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed 19 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 10/25/29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull
Run down by auto causing
the ator injury

(duration) yrs. mos. ds.

CONTRIBUTORY Cerebral Hemorrhage
(Secondary)
Broncho Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Gay & Fallsway

Did an operation precede death? no Date of

Was there an autopsy? no Clinical

What test confirmed diagnosis? H. Frame

(Signed) M. D.

10/25/1929 (Address) 2929 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	19
20 UNDERTAKER Commissioner Health.	ADDRESS

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50607 S+Co

CERTIFICATE OF DEATH

90 E 50607

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Southwestern P. S. St. 14-28 Ward)

2-FULL NAME William N. Tyler

(a) RESIDENCE NO. No None St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Unknown
(Address) UNIVERSITY OF MARYLAND

15 Filed 1929, 19 C. HAMPSON JONES, M. D.
Registrar

4024

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H. Traverse M. D.

Oct 20. 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER Commissioner Health.	ADDRESS

Important. See instructions on back of certificate.

Prof. Print E. Woodall

Spec.—1-10-21—M&T—1500 Blks.

E 50608 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50608

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 Bayard- ST. 21-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Woodall

(a) RESIDENCE NO. 1228 Bayard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Woodall

6 DATE OF BIRTH (month, day, and year) Aug-6-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brookeyn md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George Woodall

(Address) 1228 Bayard

15 Filed 1 1929 O. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Oct 31, 1929, that I last saw her alive on Oct 30 1929, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(duration) — yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Gall stones

(duration) Coincident ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) David Druckman M. D.

10/31 1929 (Address) 1227 W Lee 16

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 11/2 1929

20 UNDERTAKER Walter B Spriggs

ADDRESS 1394 Hanover St

FROM IS very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50609 E 50609 90

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 144 Moshier ST. 14-20 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Florida Roy

(a) RESIDENCE NO. 144 Moshier ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alpheous Roy

6 DATE OF BIRTH (month, day, and year) Dec 12 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	69	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Stockbridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lyda Roy
(Address) 144 Moshier

15 Filed 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Oct 31, 1929, that I last saw h.. alive on Oct. 30, 1929 and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Endocarditis

Arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank T. Hinds, M. D.

. 19 (Address) 405 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 2 1929
20 UNDERTAKER	ADDRESS
D. M. W. & E. Deppler	32 Conant

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50610

CERTIFICATE OF DEATH

101-001 E 50610

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 7-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Wittmer

(a) RESIDENCE NO. 2603 E. Monument ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Wht	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Wittmer

6 DATE OF BIRTH (month, day, and year) Feb 7 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R. R.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Philip Wittmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa Wittmer

(Address) 2603 E. Monument St

15 Filed 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Oct 31, 1929

that I last saw him alive on Oct 31, 1929

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia - Right lower lobe

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis H. M. Krauss M. D.

19 (Address) 20 E. Preston St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon P[illegible] Cem[illegible]	11/4/29
20 UNDERTAKER Geo Lembach & Son	ADDRESS [illegible]

Spec.—8-16-29—L. F. S.—100 Blks.

Dr Long 800 E, Baston St ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50611

CERTIFICATE OF DEATH

31 E 50611

1—PLACE OF DEATH 1520 Madeira st

CITY OF BALTIMORE: (No. 906 N Gay ST. 16-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank X. Riederer

(a) RESIDENCE NO. 906 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M Riederer

6 DATE OF BIRTH (month, day, and year) Nov 13th 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baughter Iron Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank X Riederer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Maria Seubert

(Address) 1520 Madeira st.

15 Filed 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH 2 P.M.

16 DATE OF DEATH (month, day, and year) Nov 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 19 29, to Nov 1, 19 29, that I last saw him alive on Oct 31, 19 29, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Pulm T. B.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

10/31/29 (Address) 800 E. Baston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	11/4 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

E 50612

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 50612

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospt. REGISTERED NO.

CITY OF BALTIMORE: (No. 12 Balto Md. ST. 21-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie a Jones vs Schmidt

(a) RESIDENCE NO. 2109 Vine St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 637

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Records
(Address) Balto City Hospital

15 Filed 1 1929 19

C. HAMPTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1-29

17

I HEREBY CERTIFY, That I attended deceased from 3-2-, 19 28 to 11-1, 19 29

that I last saw h ev alive on 10-31-, 19 29

and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Serological & Clinical findings

(Signed) Harry [illegible] M. D.

11/1, 1929 (Address) Balto City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Nov 4th 1929
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50613

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 E 50613

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S Chapel ST. 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Bach

(a) RESIDENCE NO. 319 S Chapel ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B Bach

6 DATE OF BIRTH (month, day, and year): March 17-1849

7 AGE — Years: 80 | Months: 7 | Days: 14 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Emma Bach

(Address): 319 S. Chapel

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 1-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 28 to Nov 1 19 29

that I last saw her alive on Oct 31 19 29

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Buccal Carcinoma

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Toxic Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Wood M. D.

11/1 19 29 (Address) 413 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cem — DATE OF BURIAL: 11/4 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50613

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 242 Rock ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia Russell

(a) RESIDENCE NO. 200 Gilmore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Russell

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 60 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Maryland

10 NAME OF FATHER: Dennis Camper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Maryland

12 MAIDEN NAME OF MOTHER: not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Maryland

14 Informant: Mary J. Camper

(Address) 1119 N. Carrollton Ave.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-31-29

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1929, to 10-31, 1929, that I last saw h er alive on 10-29, 1929 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

myocarditis

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical Signs & Symptoms

(Signed) John E. Camper, M. D.

. 19 (Address) 724 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Nov 2 1929

20 UNDERTAKER: John H Toadvine — ADDRESS 1029 Hanover St

Spec.—2-29-28—L. F. S.—500 Blks.

E 50615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 84 ✓E 50615

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laurence H. Yohe Jr.

(a) RESIDENCE NO. 343 Cottage Hill Rd. York, Pa. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 30, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	11	10	2 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) York, Pa.

10 NAME OF FATHER Laurence H. Yohe Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) York, Pa.

12 MAIDEN NAME OF MOTHER Eleanor Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York, Pa.

Informant Father. Laurence H. Yohe

(Address) 343 Cottage Hill Rd. York Pa

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1929, to Nov. 2, 1929

that I last saw him alive on Nov. 2, 1929

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Cerebellar.

(Type undetermined)

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Shock, Post operature

(duration) ... yrs. ... mos. 3/4 ds.

18 Where was disease contracted if not at place of death? Undetermined.

Did an operation precede death? Yes Date of Nov. 1, 1929

Was there an autopsy? No.

What test confirmed diagnosis? X-rays.

(Signed) Samuel McLanahan, M. D.

Nov. 2, 1929 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem. York Pa	Nov. 4 1929
20 UNDERTAKER	**ADDRESS**
Wm. J. Tuckner & Son	York Pa

Spec.—2-29-28—L. F. S.—500 Bks.

E 50616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-00 E 50616

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1260 Battery Ave (St.) 24-33 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J Summers

(a) RESIDENCE NO. 1260 Battery Ave 24th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced — HUSBAND of (or) WIFE of: -

6 DATE OF BIRTH (month, day, and year): April 6 1877

7 AGE — Years: 52 — Months: 6 — Days: 24 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipyard worker

(b) General nature of industry, business, or establishment in which employed (or employer): Shipyard 086

(c) Name of employer: Obrecht Lynch Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: William E Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Crisfield Md

12 MAIDEN NAME OF MOTHER: Zippora M Meekins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md

14 Informant: Mrs Zippora M Summers
(Address): 1260 Battery ave

15 Filed: C. HAMPSON JONES, M. D. Registrar
1929 Per dd K

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 30/1929

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1929 to October 30, 1929.
that I last saw him alive on October 30 1929
and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

(duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary): Arterio sclerosis

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F Buettner, M. D.
Oct 31. 1929 (Address) 1319 Light St, Balto, Md.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Nov. 2 1929
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

Spec.—1-10-21—M&T—1500 Bks.

E 50617

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50617

CERTIFICATE OF DEATH.

101 001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2502 Rayner Ave (Ward) 16-68

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levin Cure

(a) RESIDENCE NO. 2502 Rayner Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Martha Cure

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 !			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co
(State or country) Md

PARENTS

10 NAME OF FATHER John Cure

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Martha Cure
(Address) 2502 Rayner ave.

15 Filed 1929, 19 ... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Oct 29, 1929, that I last saw h[im] alive on Oct 29, 1929, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C William Frey M. D.

10/30, 1929 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Nov. 3, 1929

20 UNDERTAKER: Mrs. Kate F. Williams — ADDRESS 322 N Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50618

CERTIFICATE OF DEATH

31 √ E 50618

1—PLACE OF DEATH

CITY OF BALTIMORE; (No.) 816 Pierce ST. 17-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie O. Jones

(a) RESIDENCE NO. 816 Pierce ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14, 1911

7 AGE: Years 18 Months 6 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Prince George Co. (State or country) Va

10 NAME OF FATHER Paul Jones

11 BIRTHPLACE OF FATHER (city or town) Chesterfield Co (State or country) Va.

12 MAIDEN NAME OF MOTHER Minnie Lee

13 BIRTHPLACE OF MOTHER (city or town) Greenville Co (State or country) Va

PARENTS

14 Informant Minnie Jones
(Address) 816 Pierce st

15 Filed 1929 19 HAMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 15 1929 to Oct 30 1929 that I last saw h[illegible] alive on Oct 30 1929 and that death occurred, on the date stated above, at 8.46 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Nov. 2, 1929

20 UNDERTAKER: Dr. Nettie R. Williams

ADDRESS 3224 Schroeder St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50619

HEALTH DEPARTMENT—CITY OF BALTIMORE

138 E 50619

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Martin

(a) RESIDENCE NO. 520 Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 0 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Laurence Martin

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 910

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Orangeburg S. C.

10 NAME OF FATHER Benny Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Laurence Martin

(Address) 234 N. Fremont Ave

15 Filed 1929, 19 C. HAMPSON JONES, M. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-29

17 I HEREBY CERTIFY, That I attended deceased from 10-14, 1929, to 10-27-, 1929, that I last saw her alive on 10-27, 1929, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pelvic abscess

(duration) about yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) generalized peritonitis.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 10-25-29

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) E. W. Peake, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Nov. 2 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N Schroeder St

Cor.—12-9-25—A Co.—200 Bks.

E 50620 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50620

90

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2111 Oak St St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henetta Johnson

(a) RESIDENCE NO. 2111 Oak St St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: George W. Johnson

6 DATE OF BIRTH (month, day, and year): Unknown, 1877

7 AGE — Years: 52 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Unknown

PARENTS

10 NAME OF FATHER: George W. Green

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ga

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Unknown

14 Informant: Gertrude Johnson

(Address): 2111 - Oak St

15 Filed....., 19..... Registrar

C. HAMPSON JOHNSON

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10-30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Wm H Grossley M. D.

(Coroner)

11/1, 1929 (Address) 1632 Riland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lochlawn Md — Date of Burial: Nov. 2 1929

20 UNDERTAKER: Wm. P. G. Elliott — ADDRESS: 1745 Ashland ave

Spec. 6-8-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50621

CERTIFICATE OF DEATH.

47 E 50621

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE NO. 916 N. Gilmor ST. WARD 16-22

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza S. Talley

(a) RESIDENCE. NO. 916 N. Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Talley

6 DATE OF BIRTH (month, day, and year) Jan 10 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Priscilla Fisher
(Address) 916 N. Gilmor St

15 Filed 2 1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1925 to Oct 30, 1929, that I last saw her alive on Oct 29, 1929, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

Aug 1925 Oct 1929
(duration) yrs mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Forsyth, M. D.

19 [illegible] 19 (Address) 1111 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	11/2/1929

20 UNDERTAKER Jno. Geo. H. Holland ADDRESS 163 Druid Hill

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50622

CERTIFICATE OF DEATH

191 E 50622

1-PLACE OF DEATH

City of Baltimore: (No. 1115 N. Parrish St. 16-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laurnia Lucas

(a) RESIDENCE NO. 1115 N. Parrish St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmal	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Mar 30-1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	6	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Payton Lewis

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Alice Bell

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Alice Lewis
(Address) 1115 N. Parrish

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar
NOV 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour) Oct 29th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Pistol wound of brain
Sudden
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1115 N. Parrish

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Degnan McKenrick M. D.
Oct 30 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Nov. 2 1929
20 UNDERTAKER	ADDRESS
Thomas G. Kelson	1307 Pennsylvania Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50623

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50623

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1312 N. Carey ST. 15-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irvin K. Williams

(a) RESIDENCE NO. 1312 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word):

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 12. 1929

7 AGE — Years: — Months: 2 Days: 19 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of indostry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

10 NAME OF FATHER Richard Williams

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Ada Carter

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mrs Ada Carter

(Address) 1312 N. Carey

Filed 1929, 19 Par Mar C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 31 1929 to Nov 1 1929

that I last saw him alive on Nov 1 1929

and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas E. Doll, M. D.

, 19 (Address) 719 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: NOV 2 1929

20 UNDERTAKER: Thomas E. Kalson — ADDRESS: 1203 Pierstman St

Spec.—2-29-28—L. F. S.—500 Hks.

E 50624

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50624

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Edmondson Ave 16-27 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Nannie Matthews

(a) RESIDENCE NO. 1700 Edmondson Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Matthews

6 DATE OF BIRTH (month, day, and year) Aug. 23. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Charles Co. Md

10 NAME OF FATHER William Shark

11 BIRTHPLACE OF FATHER (city or town) Charles Co. (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Jane Coates

13 BIRTHPLACE OF MOTHER (city or town) Charles Co. (State or country) Md

Informant Mrs. Myrtle Watson

(Address) 1700 Edmondson Ave.

Filed ..... 19 ..... Registrar

NOV 2 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Nov 1, 1929

that I last saw her alive on Nov 1, 1929

and that death occurred, on the date stated above, at 9:50 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

& Heart

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr E Ekell, M. D.

, 19 (Address) 1 E Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov. 4 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

Spec.—I-10-21—M&T—1500 Blks.

E 50625 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50625

CERTIFICATE OF DEATH.

109-002

1-PLACE OF DEATH U.S. Marine Hospital Baltimore, Md.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 95-77 ST. WARD)

2-FULL NAME Joseph Kadan

(a) RESIDENCE NO. 4101 Fairhaven Ave., Curtis Bay, Md. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Kadan

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1874

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or min.
	55	1	12	//

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Civil Employee

(c) Name of employer U.S.C.G.Depot, Curtis Bay

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Kadan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Barbara ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 1, 29

17 I HEREBY CERTIFY, That I attended deceased from October 29, 19 29 to November 1, 19 29, that I last saw him alive on November 1, 19 29, and that death occurred, on the date stated above, at 11:05 A.m.

The CAUSE OF DEATH* was as follows:

Retropharyngeal abscess

(duration) yrs. mos 36 ds.

CONTRIBUTORY (Secondary) secondary hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Oct.30, 1929

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) [signature] M. D.

11/1, 19 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL Nov 4 19 29

20 UNDERTAKER Fred Bracken — ADDRESS 1906 Eutaw

C. HAMPSON JONES, A.M. M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50626

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3509 Mt. Pleasant Av ST. 26-37 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lula D. West

(a) RESIDENCE NO. 3509 Mt. Pleasant Av ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Chas. M. West

6 DATE OF BIRTH (month, day, and year): Aug 6/81

7 AGE: Years 48 | Months 2 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): City

10 NAME OF FATHER: John J. Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah E. Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: Chas. M. West

(Address) 3509 Mt Pleasant Av

Filed Nov 2, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31/29

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Oct 31, 1929, that I last saw h alive on Oct 31 1929, and that death occurred, on the date stated above, at 1 35 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(Condition) Bronchial yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Brown, M. D.

(Address) 4 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood

DATE OF BURIAL: Nov 2 1929

20 UNDERTAKER: Philip Henry

ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50627

CERTIFICATE OF DEATH

48 E 50627

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2200 Cecil Ave ST., 9-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Yahn

(a) RESIDENCE NO. 2200 Cecil Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of late John Yahn

6 DATE OF BIRTH (month, day, and year) Sept 9/60

7 AGE: Years 69 | Months 1 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Herman H. Beinke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dec

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

Informant Mrs. R. B. Yingling

(Address) 2200 Cecil Ave

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31/29

17

I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1928, to Oct 31st, 1929, that I last saw h[illegible] alive on Oct 31st 1929 and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Cancerous Ulcer of Face

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George E. Cross, M. D.

, 19 (Address) 28 W 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem.	Nov 2 1929
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans St.

Cor.—10-10-29—A Co.—100 Bks.

E 50628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

199 E 50628

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1501 W Saratoga St., 1927 Ward)

2-FULL NAME Preston Mills

(a) RESIDENCE NO. 1501 W. Saratoga St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alice Mills

6 DATE OF BIRTH (month, day, and year) October 25 1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	0	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab —
(b) General nature of industry, business, or establishment in which employed (or employer) O'H'D
(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER Henry Mills

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Leah Seaton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N C

14 Informant Alice Mills
(Address) 1501 W Saratoga

15 Filed ....., 19... C. HAMPSON JONES M. D. Registrar

1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Coachman Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooks M. D.

Nov. 1. 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL Nov 3 1929

20 UNDERTAKER Joseph A Sively ADDRESS 409 N Mount St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 50629

1—PLACE OF DEATH St. Joseph's Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oliver ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Williams

(a) RESIDENCE NO. 2940 Hudson Sts ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Minnie Williams.

6 DATE OF BIRTH (month, day, and year) July-9-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machanic.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago Ill.

10 NAME OF FATHER Thomas Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago Ill

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Minnie Williams

(Address) 2940 Hudson St.

FILED 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1/29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1929, to Nov. 1, 1929

that I last saw h— alive on 11/1/29, 19

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Empyema - right lung

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Toxic Fever

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/30/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V. Messina, M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery.	Nov. 4- 1929.
20 UNDERTAKER	ADDRESS
Charles J. Schwab	505 N. Monroe St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50630

CERTIFICATE OF DEATH

3 1 √ E 50630

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore, Hosp St.) 16-27 Ward)

2-FULL NAME Joel Bailey

(a) RESIDENCE NO 627 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of cesidence in city or town whece death occurred 4 yrs. mos. ds. How long in U. S., If of foceign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Married

5a If maccied, widowed, oc divoreed
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. oc ..... min.
	36	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) Genecal nature of industry, business, or establishment in which employed (or employer)
(c) Name of employec

9 BIRTHPLACE (city or town) .....
(State or country) Va.

PARENTS

10 NAME OF FATHER Robert Bailey

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Taylor

13 BIRTHPLACE OF MOTHER (city oc town) .....
(State or country) Va

14 Informant Geo P. Bailey
(Address) 627 N. Mount St

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 - 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fell DB-

(duration) .. yrs. .. mos. 1 ds.

CONTRIBUTORY (Secondary) Ex Laudanum

(duration) .. yrs. .. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there a autopsy?

What test confirmed Diagnosis?

(Signed) H. C. Hampson, M. D.

. 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injucy, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wakefield Va	11-2 1929
20 UNDERTAKER	ADDRESS
Daniel Easton	Va

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50631

CERTIFICATE OF DEATH

90

E 50631

1—PLACE OF DEATH

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4304 Springwood ST. Ave. WARD 26-43)

2—FULL NAME Minnie F. Murphy.

(a) RESIDENCE NO. 4304 Springwood ST Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Murphy.

6 DATE OF BIRTH (month, day, and year): Nov. 1st 1869

7 AGE: Years 60 | Months 11 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country): West Va.

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): West. Va

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Va.

Informant: Mrs. Rose F. Bell

(Address) 4304 Springwood Ave

Filed ____, 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 10/31/29

17 I HEREBY CERTIFY, That I attended deceased from 3/14/29, 19__, to 10/31/29, 19__, that I last saw h__ alive on 10/26/29, 19__, and that death occurred, on the date stated above, at 9.50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease.

(duration) yrs. 7 mos. 17 ds.

CONTRIBUTORY (Secondary): Cardiac decompensate

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? h

Did an operation precede death? h Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. A. Lawder, M. D.

10/31, 1929 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Nov 4th 1929.

20 UNDERTAKER: John Howard & Son

ADDRESS: York Road

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50632

CERTIFICATE OF DEATH

118-002

E 50632

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD) 11-19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alfred Tyler Jr

(a) RESIDENCE NO. St Paul & Preston Sts. ST., East Court Apt WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. — mos. 30 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Oct 2, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	—	30 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banking

(b) General nature of industry, business, or establishment in which employed (or employer) Banking 856

(c) Name of employer Union Trust Co.

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Alfred Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anne Johnson Poe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant Alfred Tyler

(Address) St Paul & Preston Sts

Filed NOV 3 1929 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Nov 1, 1929, that I last saw him alive on Nov 1, 1929, and that death occurred, on the date stated above, at 9 45 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Princeton N. J.

Did an operation precede death? Yes Date of Oct 30, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) James Alan Mumbry, M. D.

11/1/1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Nov 4 1929
20 UNDERTAKER	ADDRESS
Geo J Jenkins Co Inc	Oakland & McCulloh Sts

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50633 ✓ E 50633

CERTIFICATE OF DEATH

45

E 50633

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No.) Preston Apts Preston St. & Linden Ave (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Gooch Simpson

(a) RESIDENCE NO. Preston Apts ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5-1884

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer) Fed. Res. Bank

(c) Name of employer N. Y.

9 BIRTHPLACE (city or town) Hendersbn
(State or country) N. C.

10 NAME OF FATHER Shodrach Simpson

11 BIRTHPLACE OF FATHER (city or town) Rockingham
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ell Eugenia Gooch

13 BIRTHPLACE OF MOTHER (city or town) Henderson
(State or country) North Carolina

14 Informant Earle Simpson
(Address) Boston Mass.

15 Filed NOV 3 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2/1929.

17 I HEREBY CERTIFY, That I attended deceased from August 27, 1929, to Nov. 2d, 1929, that I last saw h alive on Nov 1st, 1929 and that death occurred, on the date stated above, at 1.09 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 3½ da.

CONTRIBUTORY (Secondary), General abdominal carcinoma
toxa. Pneumonia, Colon & Rectum. (duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 04 29

Was there an autopsy? no.

What test confirmed diagnosis? Operation

(Signed) Henry M Stillwagon, M. D.

Nov 2. 1929 (Address) Western Motor, Maryland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Nov 4th 1929
20 UNDERTAKER	ADDRESS
Henry H. Perkins Sons	McCulloh & Orleans St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2299050634 100-001 ✓ E 50634

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Cook

(a) RESIDENCE NO. 1209 Eutaw Place ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 8/16-69

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Eagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-1-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1929, to Nov 1, 1929, that I last saw h.r alive on Nov 1, 1929 and that death occurred, on the date stated above, at 10 5 P m.

The CAUSE OF DEATH* was as follows:

Myocardial failure — hrs.

B Bronchopneumonia 5 Days

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble M. D.

Nov. 1929 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Nov 1 1929
20 UNDERTAKER Kenny & Jenkins Bros	ADDRESS McCulloh-Orchard Sts

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50635

CERTIFICATE OF DEATH

66 E 50635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital 4-1 St., Ward)

2-FULL NAME Frank Lacy

(a) RESIDENCE NO. Mulburn St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
about	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Soldier
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant W.S. Vet Bureau
(Address) Test mo Hosp

15 Filed ..... G. HAMPSON JONES, M. D.
NOV 3 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. C. Blake, M. D.

. 19 (Address) 4376 Berry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U.S. National Cem	11/4 1929
20 UNDERTAKER Richard Brooks & Son	ADDRESS Calhoun Hollins St

Spec.—1-12-23—M&T—500 Blks.

E 50636 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50636

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Belvedere & Greenspring Ave ST. 27-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alta Borenstein

(a) RESIDENCE NO. Hebrew Home for Aged and Infirm ST. WARD

(Usual place of abode) Belvedere & Greenspring (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Louis Borenstein

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	87	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Sigmund Feinblatt
(Address) Belvedere & Greenspring

15 Filed 1929 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Nov 2, 1929, that I last saw her alive on Nov 2, 1929 and that death occurred, on the date stated above, at 12 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum Exam

(Signed) Irma Miller M. D.

11/2, 1929 (Address) 3679 McHenry ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Ground — DATE OF BURIAL 11/3 1929

20 UNDERTAKER Jack Levin — ADDRESS 1429 E Balt

Spec.—8-16-29—L. F. S.—100 Bks.

1223 N Caroline St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50637

CERTIFICATE OF DEATH

78 E 50637

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 519 E 28th St. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME H. Stanley Gladfelter

(a) RESIDENCE NO. 519 E 28th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 3. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	1	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Howard Gladfelter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Christina Thalmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Christina Gladfelter

(Address) 519 E 28th St

Filed NOV 3 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1. 1929

17 I HEREBY CERTIFY, That I attended deceased from About 1895 to Nov. 1 — 19 29.

that I last saw h.i.m alive on Nov. 1 — 19 29

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 31 yrs. mos. da.

CONTRIBUTORY (Secondary) Coma

(duration) — yrs. — mos. 5 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

11/1. 1929 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 11/4 19 29

20 UNDERTAKER D. Wm. Cook

ADDRESS 1219 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Glick 3914 Park Heights Liberty 3185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50638 — REGISTERED NO. E 50638

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2325 E Federal ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida F. Hubbard

(a) RESIDENCE NO. 2325 E Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar S. Hubbard

6 DATE OF BIRTH (month, day, and year) Mar 9th 1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Whitman Md

PARENTS

10 NAME OF FATHER Reuben Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hester Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Alice Tolly

(Address) 2325 Federal st

15 Filed ..... 19 ..... Registrar

W S - 1929 HAMPSON GAINES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1. 1929 to Nov 1 1929, that I last saw her alive on Oct. 31. 1929 and that death occurred, on the date stated above, at 4.50 A M.

The CAUSE OF DEATH* was as follows:

Cancer of the Liver

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 1929.

Was there an autopsy? No.

What test confirmed diagnosis? clinical & operation

(Signed) Samuel S. Glick, M. D.

19 (Address) 3914 Park Hts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 4th 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr McGarell 633 S Conkling st or 3rd st

E 50639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 Ward 52 43

REGISTERED NO. E 50639

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2501 E. Chase ST. 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elsie M. Henninger

(a) RESIDENCE NO. 2501 E. Chase St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 2 1929

7 AGE — Years: | Months: 1 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edward Henninger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Marie Hammersbacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Maria Henninger

(Address) 2501 E Chase St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2nd 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/29/29, 19..., to 11/2, 19 29, that I last saw h alive on 11/1/29, 19..., and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

CONTRIBUTORY (Secondary) acute myocarditis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? — (duration) yrs. mos. 1 ds.

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. McGarell, M. D.

(Address) 633-S-Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 11/4 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul st

Spec.—8-16-29—L. F. S.—100 Bks.

Dr White 3005 St Paul St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50640 — CERTIFICATE OF DEATH 179 — E 50640

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2717 St Paul ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C Taylor

(a) RESIDENCE NO. 2717 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 29 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A Stone

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Elizabeth McIntyre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant L Bruce Wolcott

(Address) 2717 St Paul St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1. 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Nov 1st, 1929, that I last saw h[illegible] alive on Nov 1st, 1929 and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical examination

(Signed) M Talbot Rush, M. D.

, 19 (Address) 3005 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 11/4 1929

20 UNDERTAKER W. Cook — ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

E 50641

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50641

CERTIFICATE OF DEATH

100-02

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp. 2-4 Ward)

2-FULL NAME Deming Gragher.

(a) RESIDENCE NO. 1711 Lancaster St., 20 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Texas

PARENTS

10 NAME OF FATHER Geo Gragher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Usa

12 MAIDEN NAME OF MOTHER Nellie Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Balto City Hosp.
(Address)

15 Filed NOV 3 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) 5 yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) C. E. Gladys M. D.

(Address) 143 W. Lang

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leonard Texas	11-3 1929
20 UNDERTAKER	ADDRESS
Daniel Carey	Balto

Important.—See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929

E 50642

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1132 Wilmer St. 17-24 Ward)

2-FULL NAME Lillie Parker

(a) RESIDENCE NO. 1132 Wilmer St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem'l	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jesse Parker

6 DATE OF BIRTH (month, day and year) Oct 5-1899

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	30	—	28 27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country) "

PARENTS

10 NAME OF FATHER Anthony Bowen

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Lavinia Stewart

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country) "

14 Informant Charlotte Bowen
(Address) 1132 Wilmer St

15 Filed ....., 19.. H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 2nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (duration) — yrs. 6 mos. — ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Douglas Finch M. D.
Nov 2nd (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-4 1929
20 UNDERTAKER Daniel Eaton	ADDRESS 916 Penna Ave

Important. See instructions on back of certificate.

3-1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50643

CERTIFICATE OF DEATH

46

E 50643

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 E. Eager ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa Sentlach

(a) RESIDENCE NO. 1309 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

a If married, widowed, or divorced (or) WIFE of William F. Sentlach

6 DATE OF BIRTH (month, day, and year) 2nd Nov

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER Andrew Jamison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

Informant: Mr. William F. Sentlach

(Address) 1309 E. Eager St

Filed 3-1929, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1929, to Nov. 1, 1929, that I last saw h alive on Nov. 1, 1929, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 21

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Joseph L. Valentine, M. D.

Nov. 1, 1929 (Address) 17 S. Stricker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov. 5 1929

20 UNDERTAKER: Henry Strech Sons, Inc. — ADDRESS: 1301 E. Eager St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

E 50644

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 956 Augusta ST. 10-14 (WARD)

2—FULL NAME Margaret Horgan

(a) RESIDENCE NO. 956 Augusta ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If foreign birth? Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late John Horgan

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: About | Years: 66 | Months: — | Days: — | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Chicago Ill

10 NAME OF FATHER: Joseph Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Mrs Mary A Hughes

(Address): 956 Augusta St

Filed: NOV 3 - 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): NOV 2 - 1929

17 I HEREBY CERTIFY, That I attended deceased from January 27 1929 to November 2 1929, that I last saw her alive on November 2 1929, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Carcinoma of Breast

(duration) 2 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual Symptoms

(Signed) Mary Flaherty, M. D.

11-3, 1929 (Address) 1028 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Nov. 5 1929

20 UNDERTAKER: Henry Hood & Sons Inc — ADDRESS: 131 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO. E 50645

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 603 N Caroline ST. 7-9 WARD)

2—FULL NAME James H Dickson

(a) RESIDENCE NO. 603 N Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): divorced

6 If ~~married~~, ~~widowed~~, or divorced HUSBAND of (or) ~~WIFE of~~: Kate Palmer

7 DATE OF BIRTH (month, day, and year): Jan 7, 1854

8 AGE: Years 75 Months 9 Days 24. If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal Heaver

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): VW

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

Informant: Estella A. Dilgham (daughter)

(Address) 2614 Druid Hill Ave

Filed 3-1929 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Oct 31, 1929, that I last saw h. ~~him~~ alive on Oct 30, 1929 and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Acute Hypo static Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Lung Disease and Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical.

(Signed) R. F. Hartung, M. D.

10/2. 1929 (Address) 1424 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	11/3/1929
20 UNDERTAKER	ADDRESS
Mrs. Geo. H. Holland	1031 Druid Hill

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50646

CERTIFICATE OF DEATH.

84 E 50646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5302 Carter Ave (ST.) 27-44 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Barnickel

(a) RESIDENCE NO. 5302 Carter Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ Christina Barnickel

6 DATE OF BIRTH (month, day, and year) Aug 29 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical

(b) General nature of industry, business, or establishment in which employed (or employer) Under

(c) Name of employer retired

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Barnickel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Reubauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christina Barnickel
(Address) 5302 Carter Ave

15 Filed 3 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV. 1 1929

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to Nov 1, 1929, that I last saw him alive on Oct 31, 1929 and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Multiple Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

11/1 (Signed) Hilz & Kinzer, M. D.

, 1929 (Address) 2700 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Sepulchre

DATE OF BURIAL Oct 29 1929

20 UNDERTAKER Martin E Duffy

ADDRESS 375 Lynn St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 50647

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST., 17-24 WARD)

2—FULL NAME John A. J. Zipp

(a) RESIDENCE NO. 520 St. Mary ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne S. Zipp

6 DATE OF BIRTH (month, day, and year): Sept. 3 1884

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
45	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bryson Mason School

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: John L. Zipp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Cromwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Anne S. Zipp - Wife

(Address) 520 N. Mary St.

15 Filed 3 1929 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Oct. 30 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1929, to Oct. 30, 1929.

that I last saw h-im alive on Oct. 30, 1929

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Syphilitic heart disease C aortic insufficiency & congestive heart failure.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia. Uremia

(duratinn) yrs. mos. 2 ds.

18 Where was disease cnntracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. F. Varney M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, nr in deaths frnm Vinlent Causes, state (1) Means and Nature nf Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Nov. 3 1929

20 UNDERTAKER: John M. Johnson

ADDRESS 2320 Madison Av.

Spec.—2-29-28—L. F. S.—500 Blks.

E50648 HEALTH DEPARTMENT—CITY OF BALTIMORE E50648

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO. [redacted]

CITY OF BALTIMORE: (No. Mt Pleasant Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ralph Smith

(a) RESIDENCE NO. Powlandville Md WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 26 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. S.

PARENTS

10 NAME OF FATHER Harry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Frances Calhoun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hospital records
(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3/29

17 I HEREBY CERTIFY, That I attended deceased from 10-28-29 to 11-3-29 19 ,

that I last saw h.. alive on 11-3-29 19 and that death occurred, on the date stated above, at 5.58 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Hemorrhage

(duration) yrs. 2 mos. 12 ds.

CONTRIBUTORY (Secondary) Active Pulmonary T. B.

(duration) 16 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10/26/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Wm. Kirby, M. D.

(Address) Mt Pleasant Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rising Sun Md	Nov 6 1929
20 UNDERTAKER J. C. Tyson.	ADDRESS Rising Sun Md

NOV 4 1929 HARRISON JONES M.D. Registrar

Spec.—1-10-21—M&T—1500 Blks.

[redacted] HEALTH DEPARTMENT—CITY OF BALTIMORE 1850249

CERTIFICATE OF DEATH. X 49 [redacted]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. (St.) 11-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Venzkel

(a) RESIDENCE No. Bradshaw, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 11, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co., Md.

PARENTS

10 NAME OF FATHER James S. Cage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George's Co. Md.

12 MAIDEN NAME OF MOTHER Mary J. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant Hospital record
(Address)

15 Filed NOV 4 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3- 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-18-29, 19... to 11-3-29, 19...

that I last saw h[illegible] alive on 11-3-29, 19...

and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of Pancreas

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10-25-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon, Harford Co. Md.	Nov. 6, 1929
20 UNDERTAKER	ADDRESS
H. K. McComas	Abingdon Md.

Cor.—10-10-29—A Co.—100 Bks.

E50650

HEALTH DEPARTMENT—CITY OF BALTIMORE

E50650

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 3-4 Ward)

2-FULL NAME Leonora Kocan

(a) RESIDENCE NO. 331 S Caroline St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? 17 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bellie Kocan

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
36.	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poske. Poland
(State or country)

PARENTS

10 NAME OF FATHER Simon Mazura

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Anna Heal

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Joseph Mazura
(Address) Sebastian Exp. Co.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1- 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Thrombosis

Broken Compensation (duration) ..... yrs. ..... mos. 1 ds.
(Secondary)

..... (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted If not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? Yes What test confirmed diagnosis? Autopsy & History

(Signed) J. M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Polish Cem.	Nov 3 1929.

20 UNDERTAKER Wendell J. Kappel ADDRESS 3103 Eden

Important. See instructions on back of certificate.

W.A. - 1929 - HAMPSON JONES

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50651

CERTIFICATE OF DEATH.

E 50651

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Parker Hall Lee

(a) RESIDENCE No. 5319 Cordelia ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec 20-1921

7 AGE — Years: 7 Months: 10 Days: 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Parker Hall Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Belair Md.

12 MAIDEN NAME OF MOTHER: Beulah May

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Parker Hall Lee (Address) 5319-Cordelia ave

15 Filed: V 4 - 1929 G. HAMPTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-1 1929.

17

I HEREBY CERTIFY, That I attended deceased from 10-21, 1929, to 11-1, 1929.

that I last saw he alive on 10-31, 1929,

and that death occurred, on the date stated above, at 3.30 P. M.

The CAUSE OF DEATH* was as follows:

Staphylococcus Septicemia

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) [illegible] M. D.

. 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — DATE OF BURIAL: 11-4 1929

20 UNDERTAKER: Mary A. Gaughan ADDRESS: 2[illegible] E. Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50652

CERTIFICATE OF DEATH

129 ✓ E 50652

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 917 S. Fremont ave. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Parker

(a) RESIDENCE NO. 917 S. Fremont ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ollie Parker

6 DATE OF BIRTH (month, day, and year) Exact unknown 87

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42 years.			

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Laborer Gen'l

(b) General nature of industry, business, or establishment in which employed (or employer) Basket factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Annie R. Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Lillian Gross

(Address) 917 S. Fremont Ave

15 Filed 4-1929, 19 H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31/29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1. 1929. to Oct 31. 1929

that I last saw him alive on Oct 30. 1929

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ? yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. T. Carroll, M. D.

11/3. 1929 (Address) 820 Hathaway st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Nov 4 1929
20 UNDERTAKER John W. Toadvine	ADDRESS 1027 Lombard

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50653

CERTIFICATE OF DEATH

44

E 50653

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2701 Lauretta Ave WARD) 30-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Riddell

(a) RESIDENCE NO. 2701 Lauretta Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Riddell

6 DATE OF BIRTH (month, day, and year) April 14 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City Dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D C

10 NAME OF FATHER John Riddell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Nettie Sellers

(Address) 2701 Lauretta Ave

15 Filed Nov 1 1929 RHH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1929 to Nov 1 1929 that I last saw h alive on 19

and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Superintendent Bureau

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Dr L Feldmann M. D.

11/2 1929 (Address) 3700 W Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 4 1929
20 UNDERTAKER	ADDRESS
John F Denny	715 E 41st St

Cor.—12-9-26—A Co.—200 Bks.

E 50654

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37-001

E 50654

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: Johns Hopkins Hospital 26 (Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ronald Ames

(a) RESIDENCE NO. 725 Wasche St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 10-1929

7 AGE: Years 6 Months Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER William Ames

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Shooter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Janie Shooter

(Address) 2200 Madison Ave

Filed Nov 4 1929

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2/29 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis (Meningitis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. Ollis Miller (Coroner) M. D.

11/4/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem Date of Burial Nov 4 1929

20 UNDERTAKER Samuel Hemsley ADDRESS 518 N Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50655

CERTIFICATE OF DEATH

40

E 50655

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 1926 WARD)

2—FULL NAME Bessie Jones Freeland

(a) RESIDENCE NO. 1325 W. Saratoga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Separated

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Unknown

6b DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 32 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Alex. Freeland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Alberta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

Informant: Hospital Record

(Address):

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/1/29

17 I HEREBY CERTIFY That I attended deceased from 10/17 1929 to 11/1 1929

that I last saw her alive on 11/1 1929

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Left tubo ovarian abscess

Unknown (duration) yrs mos. ds.

CONTRIBUTORY (Secondary) Purulent peritonitis

(duration) yrs mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 10/17/29

Was there an autopsy? Partial

What test confirmed diagnosis? autopsy

(Signed) Lill. Lungkin, M. D.

11/2, 1929 (Address) Balt. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bury cemetery

DATE OF BURIAL: nov 4 1929

20 UNDERTAKER: Edward Bryon

ADDRESS: 1631 Orleans

Spec.—2-29-28—L. F. S.—500 Blks.

229737
E 50656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-001 E 50656

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Reid

(a) RESIDENCE NO. 1726 E Lafayette ST. ST WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3 24 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Practical Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Ost

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER James Reid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Walton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 11-4 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 2-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1929 to Nov 2 1929.

that I last saw her alive on Nov 2 1929

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Post operative hyperthyroid reaction

(duration) yrs mos 3 ds.

CONTRIBUTORY (Secondary) Hyperthyroidism

(duration) 5 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-31-29

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Frank W. Lynch, M. D.

11/2, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Nov 6th 1929
20 UNDERTAKER	**ADDRESS**
George Schilling & Sons	1216 E Monument

Spec.—2-29-28—L. F. S.—500 Bks.

E 50657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-061

E 50657

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1302 N. Stricker ST. 15-24 WARD)

2—FULL NAME James Albert Curtis

(a) RESIDENCE NO. Charlotte Hall Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) May 4- 1920

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	6	27	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Mechanicsville Maryland

10 NAME OF FATHER William Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mechanicsville Maryland

12 MAIDEN NAME OF MOTHER Laura Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mechanicsville Maryland

Informant William Curtis

(Address) Charlotte Hall md.

Filed ——, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1929, to Nov 3, 1929

that I last saw h alive on Nov. 3, 1929

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs mos. 14 ds.

18 Where was disease contracted if not at place of death? Charlotte Hall md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

11/5, 1929 (Address) 1663 W. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlotte Hall Md	Nov 4 1929
20 UNDERTAKER Thomas E. Kelson.	ADDRESS 1303 Pennsylvania Ave

Spec.—1-10-21 M&T 1500 Blks.

50658

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50658

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Greenmount Ave S. E. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Wilson

(a) RESIDENCE No. 805 Greenmount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Le	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Arthur Glasgow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Francis Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Francis Wilson

(Address) 805 Greenmount Ave

Filed NOV 4 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Nov 1, 1929.

that I last saw him alive on Nov 1, 1929.

and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs mos 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein M. D.

11/3, 1929 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Nov 4 1929

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1725 Eastland

Spec.—8-16-29—L. F. S.—100 Bks.

E 50659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50659

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 W 37th St. ST. 13-5 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Selma L. Saumwald

(a) RESIDENCE NO. 1230 W 37th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Joseph Saumwald

6 DATE OF BIRTH (month, day, and year) Sept 13-1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Hand. Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Mrs. Bell Trouble

(Address) 1230 W 37th St

Filed NOV 4 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Nov. 3, 1929, that I last saw her alive on Nov. 2, 1929 and that death occurred, on the date stated above, at 7a.m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

CONTRIBUTORY (Secondary) Gastro Enteritis (duration) yrs. mos. 1 ds.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. F. Culpeper, M. D.

11/4, 1929 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Nov 5 1929

20 UNDERTAKER Edmonds Sons

ADDRESS 3615 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50660

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50660

CERTIFICATE OF DEATH

24-004

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 N. Robinson ST., 7-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julius Hlubb

(a) RESIDENCE NO. 619 N. Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if foreign birth 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie G. Hlubb

7 DATE OF BIRTH (month, day, and year): Sept 27 1878

8 AGE: Years 51 Months 1 Days 5 If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: clothing cutter

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Austria Hungary

10 NAME OF FATHER: John Hlubb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria Hungary

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria Hungary

Informant: Jennie G. Hlubb

(Address): 619 N. Robinson st

Filed NOV 4 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/2/29.

17 I HEREBY CERTIFY, That I attended deceased from 10/1/29, 19, to 11/2/29, 19, that I last saw him alive on 11/2/29, 19, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Central Hemmorhage

(duration) yrs. mos. 1/4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Hausman M. D.

11/4/29 (Address) 2913 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Nov 7 1929

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave.

Spec.-7-17-26—A Co.—200 Bks.

Vaeth

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 ✓

E 50661

E 50661

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 16-67

City of BALTIMORE: (No. 2920 Riggs Av St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Vaeth

(a) RESIDENCE NO. 2920 Riggs Av St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John L. Vaeth

6 DATE OF BIRTH (month, day, and year)
Feb. 3, 1861.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	68	8	30 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 0-37
(b) General nature of industry, business, or establishment in whirh employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER John Wheltle

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rosette Kirkwood

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant John L. Vaeth
(Address) 2920 Riggs Ave.

15 Filed - 1929 - 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
Nov-2-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 19 29, to Nov 2, 19 29, that I last saw h alive on Nov 2, 19 29, and that death occurred, on the date stated above, at 8 00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver (duration) yrs. 11 mos ds.

CONTRIBUTORY Metastases
(Secondary)
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Evidence
(Signed) Chas E Chandler M. D.
Nov 3, 19 29 (Address) 150 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial
Catheral Cemetery — 11/5/29 19

20 UNDERTAKER Richard Thayer 1620 ADDRESS Baltimore

Spec.—2-29-28—L. F. S.—500 Blks.

E 50662

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50662

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1730 W. North Ave. (St.) 15-7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A. Shelley

(a) RESIDENCE NO. 1730 W. North Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 10 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Shelley

DATE OF BIRTH (month, day, and year) Dec. 3, 1876

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dallo

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER James Shelley

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Mary Frederick

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

Informant Mrs Annie Shelley

(Address) 1730 W. North Ave.

NOV 4 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 19 29, to Nov 1, 19 29,

that I last saw h[illegible] alive on Nov 1, 19 29

and that death occurred, an the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) 3 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Hemorrhage

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) [illegible] M. D.

11/2 '29 (Address) 1729 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Nov. 4 1929
20 UNDERTAKER	ADDRESS
Wm J Tucker & Sons	North & Pa

Cor.—10-10-29—A Co.—100 Bks.

E 50663 Johannah A. Funk

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50663

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

City of Baltimore: (No. 3202 Windsor St., 15-67 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johannah A. Funk

(a) RESIDENCE NO. 3202 Windsor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred W.

6 DATE OF BIRTH (month, day, and year): May 26-1854

7 AGE: Years 75 | Months 5 | Days 8 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0 0
(c) Name of employer

9 BIRTHPLACE (city or town): Sweden
(State or country)

PARENTS

10 NAME OF FATHER: Peter Swan

11 BIRTHPLACE OF FATHER (city or town): Sweden
(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Sweden
(State or country)

14 Informant: Ida Funk
(Address): 3202 Windsor Ave

15 Filed ..... 19..... Registrar

NOV 4 - 1929 C. HAMPSON JONES

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 3rd 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Cerebral Hemorrage)

Apoplexy (duration) Sudden

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W B C (Address) Hopkins Corner, M. D.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Nov 6 1929
20 UNDERTAKER: Wm Tuckerman Sons	ADDRESS: North Ave

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50664

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50664

38

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph C. Wright

(a) RESIDENCE NO. 639 S. Belnord Ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: ?

7 DATE OF BIRTH (month, day, and year): Dec. 2, 1871

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~58~~	57	11	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: Md. Steel Works

BIRTHPLACE (city or town) (State or country): Howard Co. Md.

10 NAME OF FATHER: Owen Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Md.

12 MAIDEN NAME OF MOTHER: ~~Mary Walker~~ Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Md.

Informant: Records of BALTIMORE CITY HOSPITALS (Address)

Filed NOV 4 - 1929 C. HAMPSON JONES, Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-3-29

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 1929, to 11-3, 1929, that I last saw him alive on 11-3, 1929 and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis

" of C.N.S.

(duration) over 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis of Aorta & Insufficiency of

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & C. Wass

(Signed) Marvin M. McLean, M. D.

11-3, 1929 BALTIMORE CITY HOSPITALS (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: Nov. 6 1929

20 UNDERTAKER: Wm. J. Tickner & Son

ADDRESS: N. Paca

Spec.—2-23-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50665

E 50665

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 N Rose ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles A. Miskimon

(a) RESIDENCE NO. 101 N. Rose ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of The late Sarah S. Miskimon

6 DATE OF BIRTH (month, day, and year) Feb 4-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sexton 070

(b) General nature of industry, business, or establishment In which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant John L Miskimon

(Address) 101 N. Rose St

15 Filed ....., 19 .....

4-1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2-29

17 I HEREBY CERTIFY, That I attended deceased from October 28, 1929, to Nov 2, 1929

that I last saw him alive on Nov 1, 1929

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address) 156 N. Wilson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	11/5/29

20 UNDERTAKER James C. Miller Sr ADDRESS 2334 Jefferson

Spec.—2-29-28—L. F. S.—500 Blks.

Schiller

HEALTH DEPARTMENT—CITY OF BALTIMORE

2305-8 E 50666

90 ✓

CERTIFICATE OF DEATH

REGISTERED NO. E 50666

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geraldine Schiller

(a) RESIDENCE NO. 3103 E. Monument ST. WARD 4-

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/24/17

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md -

10 NAME OF FATHER Wm B - Schiller

11 BIRTHPLACE OF FATHER (city or town) Ger -
(State or country)

12 MAIDEN NAME OF MOTHER Elsie Harris

13 BIRTHPLACE OF MOTHER (city or town) Md -
(State or country)

14 Informant Parents -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed V 4 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1929, to Nov. 2, 1929, that I last saw her alive on Nov. 2 1929 and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

acute rheumatic fever
Subacute bacterial endocarditis
Mitral stenosis + insufficiency
myocardial insufficiency (duration) 0 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Blood culture

(Signed) J. W. Bickford Jr. M. D.

11/2, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mathews Cemetery	Nov 4 1929
20 UNDERTAKER	ADDRESS
Mrs C. Miller & Son 2334	Jefferson

Spec.—2-29-28—L. F. S.—500 Bks.

E 50667

HEALTH DEPARTMENT—CITY OF BALTIMORE

151 ✓ E 50667

CERTIFICATE OF DEATH

1—PLACE OF DEATH Aged Womens Home

REGISTERED NO. 19-27

CITY OF BALTIMORE: (No. 1404 W Lexington ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Matilda Tutchton

(a) RESIDENCE NO. 1404 W Lexington ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 27 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Martha E Baker
(Address) 1404 W Lexington

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Nov 2, 1929,

that I last saw her alive on Nov 2, 1929

and that death occurred, on the date stated above, at 7:50 A.m.

The CAUSE OF DEATH* was as follows:

Gangrene (foot)
Senility

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical examination

(Signed) Geo. D. Rowe, M. D.

Nov 2 1929 (Address) 1115 St Paul.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Nov 4 1929
20 UNDERTAKER George J Smith	ADDRESS 531 Hollins

Spec.—1-12-23—M&T—500 Bks.

Smorgens.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50668

CERTIFICATE OF DEATH.

21-001

E 50668

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Langley ST., 25-7-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J. Smorgens.

(a) RESIDENCE No. 2203 Langley ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Oct 31 1929

7 AGE — Years: no; Months: no; Days: 4; If LESS than 1 day, hrs. or min.: 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): #

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): 2203 Langley Balto Md.

PARENTS

10 NAME OF FATHER: Edward Smorgens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Belgium

12 MAIDEN NAME OF MOTHER: Rachael Kurstick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belgium

14 Informant: Edward Smorgens

(Address): 2203 Langley St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Nov 4, 1929, that I last saw her alive on Nov 3, 1929, and that death occurred, on the date stated above, at 9:40 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) no yrs. no mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R O Gland Symptoms.

(Address) Lakeland, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Nov 6 1929

20 UNDERTAKER: George A Smith — ADDRESS: Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

E 50669 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50669

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 S. Chester ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susanna Latkowska

(a) RESIDENCE NO. 509 S. Chester ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? 48 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

9a If married, widowed, or divorced (or) WIFE of Michael Latkowski

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Sharka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Michael Latkowski

(Address) 509 S Chester Street

Filed NOV 4 - 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2 1929 to Nov. 2 1929

that I last saw h[illegible] alive on Nov. 2 1929

and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral tumor Malignant

CONTRIBUTORY (Secondary) Valvular Dis Heart. (duration) yrs. mos. 1 ds.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

19 (Address) 405 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus cemetery — DATE OF BURIAL Nov. 5 1929

20 UNDERTAKER George A. Weber — ADDRESS 705 S Ann St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50670

CERTIFICATE OF DEATH

31 E 50670

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. ..... ST., 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Wyatt

(a) RESIDENCE NO. 21 N. Spring st. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Louis Wyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed NOV 4 - 1929 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1929, to Nov. 1, 1929, that I last saw him alive on Nov. 1, 1929 and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

11-1, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Nov 4 1929
20 UNDERTAKER Wm M Chase & Son	ADDRESS 1100 Mad Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50671

CERTIFICATE OF DEATH

94 E 50671

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1013 Whatcoat St. ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert ~~Fxxxx~~ Floyd

(a) RESIDENCE NO. 1016 Whatcoat St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Floyd

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Rebecca Jordan (Daughter)

(Address) 1013 Whatcoat St.

Filed. NOV 4 1929 W. SAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-'29

17 I HEREBY CERTIFY, That I attended deceased from Oct 31st, 1929, to Nov. 3rd, 1929, that I last saw h... alive on Nov. 2nd, 1929 and that death occurred, on the date stated above, at 10.55 m.

The CAUSE OF DEATH* was as follows:

Apoplexy ~~Apoplexy~~ Apopolexy

(duration) yrs mos. 4 ds.

CONTRIBUTORY (Secondary) Arterioschlerosis - Cardiac Decomp. (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phy. exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-4 1929
20 UNDERTAKER	ADDRESS 916
Daniel Easton	8th ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50672 — 101-001 — E 50672

1-PLACE OF DEATH — REGISTERED NO.

City of Baltimore: (No. 1704 Fountain St., 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emeley Saunders

(a) RESIDENCE NO. 1704 Fountain St. 21 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	60	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Henry Nelson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER L M. Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Alma Hunter
(Address) 1204 Fountain St

15 Filed ... 19... ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest ... Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

... (duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ...

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. A. Leach, M. D. Coroner.

1704 Fountain St. (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-4, 1929
20 UNDERTAKER	ADDRESS
Daniel Carter	Balto

Fill in and write plainly with pen and ink. Do not use pencil. Do not fold this certificate.

Spec. 2-29-28—I. F. S.—500 Blks.

E 50673

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50673

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 44

CITY OF BALTIMORE: (No. 2202 Bryant Ave. WARD) 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Levy

(a) RESIDENCE NO. 2202 Bryant Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Levy

6 DATE OF BIRTH (month, day, and year): Nov. 4 1850

7 AGE: Years 78; Months 11; Days 29; If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Germany.

10 NAME OF FATHER: Isaac Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Reubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Mrs. Mad Levy

(Address): London Ave

Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 3, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Nov 3, 1929.

that I last saw h alive on Nov 3, 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) [redacted] Levitt, M. D.

, 19 (Address) 2516 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem	11/ 1929
20 UNDERTAKER	ADDRESS
David Sondheim	116-20 W. Mt. Royal Ave

A 1929 HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

50674 CERTIFICATE OF DEATH 49 E 50674

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. W-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Gauvey

(a) RESIDENCE NO. 55 South St ST., WARD
(Usual place of abode) Gettysburg Pa
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy M. Comfort

6 DATE OF BIRTH (month, day, and year) March 24 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ry. Warehouseman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W. M. Ry. Co.

9 BIRTHPLACE (city or town) (State or country) Gettysburg Penna

10 NAME OF FATHER Perry Gauvey

11 BIRTHPLACE OF FATHER (city or town) Gettysburg (State or country) Penna

12 MAIDEN NAME OF MOTHER Amanda McKnight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Jesse L. Gauvey

(Address) 32 E Baltimore St Balto Md.

Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-17-29 19... to 11-4, 1929, that I last saw h[illegible] alive on 11-4, 1929 and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-18-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) J Leyko, M. D.

11/4, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gettysburg Penna	Nov 7 1929
20 UNDERTAKER	ADDRESS
H & B Bendel Son	Gettysburg Pa

NOV 4 - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50675

CERTIFICATE OF DEATH

100-001

E 50675

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital ST. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Douglass

(a) RESIDENCE NO. 305 N Front ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	7	5	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 940

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Josephine Hurst (sister)

(Address) 915 N Caroline st

Filed ... 19.. Registrar

0V4 - 1929 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Nov 2, 1929

that I last saw h.. alive on Nov 2, 1929

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

11-3, 1929 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-6th 1929
20 UNDERTAKER	ADDRESS
Jas. Jn. Skinner	1625 E. Chase st

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50676

CERTIFICATE OF DEATH

90 E 50676

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2505 Forster ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew J. Long

(a) RESIDENCE NO. 2505 Forster ave ST., 1 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Barbara Long

6 DATE OF BIRTH (month, day, and year): April 17 1854

7 AGE — Years: 75 — Months: 6 — Days: 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: John Long

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Andrew J. Long

(Address): 2424 West St.

Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 1st 24

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Nov 1, 1924, that I last saw him alive on Nov 1, 1924, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos.

CONTRIBUTORY (Secondary): arteriosclerosis

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis Finnegan M. D.

11/4, 1924 (Address) 2431 Fait ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.).

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: Nov. 5 1924

20 UNDERTAKER: Lilly + Zeiler Inc. — ADDRESS: 403 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50677.

1—PLACE OF DEATH Balto City Hosp. 31 REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md 26-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Williams

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE: Years 24 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 37

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

Informant Records Balto City Hospitals

(Address)

Filed ....., 19 .....
Registrar

402

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-31-29

17 I HEREBY CERTIFY, That I attended deceased from 6-27-, 1928, to 10-31-, 1929

that I last saw her alive on 10-31-, 1929

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Schizophrenia, Hebephrenic Reaction Type (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Feldman, M. D.

10/31, 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

NOV 4 1929

HAMPDEN JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50678

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

CERTIFICATE OF DEATH

E 50678

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Hall

(a) RESIDENCE NO. 1728 Druid Hill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth ? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER John Sears

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ....., 19 .....

4028 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1929, to Oct. 30, 1929, that I last saw her alive on Oct. 30, 1929 and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis, Tertiary ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wass. P.C. Lab. Wass.

(Signed) Marvin M. McLean, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
ERSITY OF MARYLAND	19
20 UNDERTAKER Commissioner Health	ADDRESS NOV 4 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50679

CERTIFICATE OF DEATH

38 E 50679

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 18-26 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Taylor

(a) RESIDENCE NO. 1033 N. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth ?— yrs.— mos.— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER George Hood.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Clara ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records of

(Address) Baltimore City Hospitals

Filed 4 - 1929, 19 C. HAMILTON JONES, M. D. Registrar

4029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929 to Nov. 1, 1929

that I last saw her alive on Nov. 1, 1929

and that death occurred, on the date stated above, at 12:25 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis, Tertiary

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Tuberculosis: Cerebral Thrombosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Just PC Was

(Signed) Warren H. McLean, M. D.

(Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	NOV 4 - 1929

20 UNDERTAKER Commissioner Health

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

50680

CERTIFICATE OF DEATH

× 129 E 50680

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maude Gallen

(a) RESIDENCE NO. 6728 Evans Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. 10 mos. ?507 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

Canton Ohio

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Canton

(State or country) Ohio

10 NAME OF FATHER Sam Hill

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia, Ohio

12 MAIDEN NAME OF MOTHER Georgia ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia, Ohio

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 4030 19 H. McC. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 5, 1929, to Oct. 31, 1929, that I last saw her alive on Oct. 31, 1929 and that death occurred, on the date stated above, at 1:25 P.m.

The CAUSE OF DEATH* was as follows: Nephritis, chronic & acute

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyocarditis, chronic & acute; Arteriosclerosis, Pulmonary (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. & Path. Lab.

(Signed) Marvin H. McClean, M. D.

12-2, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

UNDERTAKER Commissioner Health

ADDRESS NOV 4 1929

Cor.—12-9-25—A Co.—200 Bks.

E 50681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 25-188-203

E 50681

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas H. Mattingley

(a) RESIDENCE NO. Mt. Raynor Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of Margaret (or) WIFE of Mattie Mattingley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer (57)

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,

(State or country) Maryland

PARENTS

10 NAME OF FATHER John F. Mattingley

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Jane Peters

13 BIRTHPLACE OF MOTHER (city or town) Cecil Co.

(State or country) Maryland

14 Informant Mr. J. C. Parker

(Address) Havre de Grace, Md.

15 Filed....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .....

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said .....

(Inquest, autopsy or inquiry.)

find that said deceased came to his death on the day stated above.

CAUSE OF DEATH* was as follows: Myocarditis

Stroke & knocked down

Explanation

(Duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Comp. Comp Back

(Duration) yrs. mos. ds.

11/4 1929 (Signed) F. D. Frame M. D.

(Coroner)

(Address) 2939 McElderry Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Nov. 5 1929

20 UNDERTAKER Joseph D. Cook ADDRESS 1003 West Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

E 50682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 50682

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4928 Belair Road ST.) (27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold George Guy

(a) RESIDENCE No. 4928 Belair Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 23 1909

7 AGE — Years: 20 — Months: 1 — Days: 10 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Atwell D. Guy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hampden Virginia

12 MAIDEN NAME OF MOTHER: Mabel Benmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belle Haven N. Carolina

14 Informant: Mabel Brown mother (Address): 4928 Belair Road

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 3 1929

17 I HEREBY CERTIFY, That I attended deceased from October 6, 1929, to Nov 3, 1929, that I last saw him alive on Nov 2, 1929, and that death occurred, on the date stated above, at 4.00 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & microscopic exam

(Signed) H. H. Emrich M. D.

1929 (Address) 2221 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem — DATE OF BURIAL: Nov 4 19 29

20 UNDERTAKER: Lost Hope — ADDRESS: 1003 N Gay St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50683 143-001 E 50683

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 948 W. Saratoga St. 18-26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lula Chaney

(a) RESIDENCE NO. 948 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Chaney

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) NC.

PARENTS

10 NAME OF FATHER Jesse Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) NC.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) NC.

14 Informant Mr. D. Chaney
(Address) 948 W. Saratoga St

15 Filed ..., 19.. G. HAMPTON MOORE, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra-partum Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Abortion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

11/4. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Henderson N C.	11-4 1929
20 UNDERTAKER	ADDRESS
Daniel Easton	Peking

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50684

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 7-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Claire Kirby

(a) RESIDENCE NO. Berkeley Springs, W. Va. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17, 1881

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
48	7	17	6 hrs. 53 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D. C. (State or country)

10 NAME OF FATHER Thomas Kirby

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Ellen Murphy

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania (State or country)

14 Informant Hospital Records

(Address)

15 Filed ..., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1929.

17 I HEREBY CERTIFY, That I attended deceased from October 7, 1929, to November 4, 1929, that I last saw her alive on November 3, 1929 and that death occurred, on the date stated above, at 6:53 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Chronic endocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) Francis W. Black, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. DATE OF BURIAL: Nov 9 1929.

20 UNDERTAKER: Reuben M Means ADDRESS: Baltimore

Spec.—8-16-29 L. F. S.—100 Bks.

E 50685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50685

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3204 Avon Ave ST., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Breidenstein

(a) RESIDENCE NO. 3204 Avondale Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clemens L Breidenstein

6 DATE OF BIRTH (month, day, and year) July 10. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 1037

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER George Distelhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Christine Morhmann

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

PARENTS

14 Informant Dorothy Edelen

(Address) 3204 Avon Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929, to Nov. 3, 1929 that I last saw h[illegible] alive on Nov. 2, 1929 and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Interstitial Nephritis
Pulmonary Edema

CONTRIBUTORY (Secondary) (duration) 5 yrs. mos. ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Callum M. D.

11/7/29 (Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 11/5 1929

20 UNDERTAKER Wm. Cook — ADDRESS 1217 St Paul St

NOV 7 1929 [illegible] Registrar

Spec.—1-10-21—M&T—1500 Bks.

E 50686 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50686

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 S. Lakewood Ave. ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank . Kudlak

(a) RESIDENCE NO. 622 S. Lakewood Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances . Kudlak

6 DATE OF BIRTH (month, day, and year) Sep . 3 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Paul . Kudlak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Barbara . Beyma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Frances . Kudlak Wife

(Address) 622 S. Lakewood Ave.

15 Filed NOV 4 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1929, to Nov. 1, 1929.

that I last saw h[illegible]live on Nov. 1, 1929.

and that death occurred, on the date stated above, at 1:45 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Bazzichini, M. D.

, 19 (Address) 735 S. Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Nov. 5 1929

20 UNDERTAKER John M. Weber ADDRESS 401 S Chester St

Spec.—1-12-23—M&T—500 Blks.

50687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 50687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST., 6427 WARD

2-FULL NAME Mrs. Rachael Orlando

(a) RESIDENCE NO. 1905 Harlem Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Joseph Orlando

6 DATE OF BIRTH (month, day, and year) Nov 2 1861.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
68.	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Orlando

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rachel Cutino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Alex Orlando

(Address) 1905 Harlem ave

Filed NOV 4 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1929. to Nov. 2 1929.

that I last saw h[illegible] alive on Nov. 2 1929.

and that death occurred, on the date stated above, at 10.40 p. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Chronic glomerulo nefritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J Mastagno M. D.

, 19 (Address) W Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11/5 1929

20 UNDERTAKER H C Branning Son

ADDRESS 1136 Poplar Grove

Spec.—1-10-21—M&T—1500 Bks.

E 50688 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50688

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 E. Lough ST 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie C. Bueche

(a) RESIDENCE NO. 1804 E Lough ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45		14	3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Sarah Zeiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address) Charles Wm. Bueche 1804 E Lough St

15 NOV 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3 1929

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to Nov. 3, 1929, that I last saw her alive on Nov. 3, 1929, and that death occurred, on the date stated above, at 9.45 m.

The CAUSE OF DEATH* was as follows:

1 Hydronephrosis - left kidney
Carcinomatosis - cervix uteri
and metastases

(duration) 1 1/2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Not since Feb. 1929 Date

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Fitch M. D.

, 19 (Address) 432 S. Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel — DATE OF BURIAL 11/4/1929

20 UNDERTAKER Louis Schumann — ADDRESS 337 E Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50689

CERTIFICATE OF DEATH

49 E 50689

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724-E Lanvale ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael P. Martin

(a) RESIDENCE NO. 1724-E. Lanvale ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L. Carroll

6 DATE OF BIRTH (month, day, and year) 5/15/1858

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	5	17	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Penna R.R.

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balt. to Md

10 NAME OF FATHER Patrick Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

Informant Mrs Anna L. Martin

(Address) 1724-E Lanvale St

FILED 1929 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2-1929

17

I HEREBY CERTIFY, That I attended deceased from May, 1929, to Nov-2-, 1929, that I last saw him alive on Nov-1-, 1929 and that death ocrurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

(duration) 1 yrs. mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease rontracted if not at place of death?

Did an operation precede death? Yes Date of May 1929

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Section

(Signed) L. N. Fargo, M. D.

, 19 (Address) 1800 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	11/5/29 19
20 UNDERTAKER George J Ruth	ADDRESS 1135 Hanover

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50690

CERTIFICATE OF DEATH

129

E 50690

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1176 Mantico 21-29 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Mack

(a) RESIDENCE NO. 1176 Mantecoke ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of: Chas. Mack

DATE OF BIRTH (month, day, and year): Aug 13 1859

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	2	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

BIRTHPLACE (city or town) (State or country): Germany.

10 NAME OF FATHER: Michael Nemer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Mrs Evans.

(Address): 1176 Manticoke St

FILED 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-3-1929

17 I HEREBY CERTIFY, That I attended deceased from 11/1, 1928, to 11/3/29, 19...,

that I last saw h[illegible] alive on 11/3/29, 19...

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Ch. Appendicitis

Ch. Dysentery

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Apoplexy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Levy, M. D.

11/4, 1929 (Address) 910 W. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	11-6th 1929
20 UNDERTAKER	ADDRESS
Bernard C Hahn	1000 E Pratt St

Cor.—10-10-29—A Co.—100 Bks.

E 50691 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50691

CERTIFICATE OF DEATH

199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mount Hope Asylum St., 15-67 Ward)

2-FULL NAME Charles Schraeder

(a) RESIDENCE NO. 3007 W North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day and year) Oct 26th 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70		7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER John Schraeder

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mathews

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Wm Zoller
(Address) 3041 W North Ave

15 Filed ....., 19.... C. HAMPSON JONES, M. D.
By ..... Registrar

- 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 3rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Fractured Skull. Struck on head with a piece of board (duration) Instantaneous

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Mt Hope

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Regular

(Signed) H. H. Houck, M. D.

Nov 4th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	11-5 1929
20 UNDERTAKER E. J. Hark 115 E North Ave	ADDRESS

Important: See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50692

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50692

CERTIFICATE OF DEATH. X 129

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO. 5772

CITY OF BALTIMORE: (No. Caton Ave & Wilkens Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary C Thomas

(a) RESIDENCE NO. Mains & Shenandoah Sts Elkridge Md WARD St Josephs Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Wm Thomas

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John W. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Sarah A. Beachamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Mrs. Hammond (Address) Mains St & Ilmaco

15 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2- 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-29 1929, to 11-2- 1929.

that I last saw him alive on 11-2 1929

and that death occurred, on the date stated above, at 11 50 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Never graduated at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry - Urinalysis

(Signed) Ernest Spencer Jr. M. D.

(Address) St Agnes Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill Cem	Nov 6 1929
20 UNDERTAKER	ADDRESS
C H Heard Evans	38 E Fort Ave

Spec.—1-12-23—M&T—500 Bks.

E 50693 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 E 50693

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balt. Genl Hosp. (Or.) 7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jay Hilton Knight

(a) RESIDENCE No. 3509 Edmondson Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie B. Knight

6 DATE OF BIRTH (month, day, and year): July 12-1886

7 AGE: Years 43 Months 3 Days 22 If LESS than 1 day, hrs. or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): City of Balto.

(c) Name of employer: Balto

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John W. Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Margaret Eibel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Marie B. Knight

(Address) 3509 Edmondson Ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Nov 4, 1929, that I last saw h[e] alive on Nov 4, 1929, and that death occurred, on the date stated above, at 12:05 A.M.

The CAUSE OF DEATH* was as follows:

General Pentanitis

Myocardial Failure

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Chr. Cholecystitis & Cholelithiasis Acute Appendicitis (Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of Oct 30 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J A Bessi M. D.

, 19 (Address) West Balto Fed Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery DATE OF BURIAL: Nov 6 1929

20 UNDERTAKER: Bertram Fore ADDRESS: 1723 N. Lafayette Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50694

CERTIFICATE OF DEATH

199 E 50694

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mount Hope Asylum 10-14 Ward)

2-FULL NAME Howard Pendleton.

(a) RESIDENCE NO. 844 E. Chase St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): 1872-

7 AGE: Years 57; Months; Days; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Falls Rd.
(State or country)

PARENTS

10 NAME OF FATHER Wm Pendleton

11 BIRTHPLACE OF FATHER (city or town) Eng.
(State or country)

12 MAIDEN NAME OF MOTHER Mary McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) Kentucky.
(State or country)

14 Informant Mt Hope Asylum
(Address) Mt Hope Balto

15 Filed ..... 19.. NOV 1929 C. HAMPSON JONES, M. D. Registrar.
per ARH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 3rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Fractured Skull
Struck on head with piece of board (duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt Hope

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. F. Bellamy M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Nov 6 1929

20 UNDERTAKER Stewart & Co — ADDRESS Baltimore

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50695

CERTIFICATE OF DEATH

90 E 50695

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2201 Elsinore Av ST. 15-61 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Henry Dankmeyer

(a) RESIDENCE NO. 2201 Elsinore Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 3 mos. 16 ds. How long in U. S., if foreign birth 56 yrs. 3 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Evelyn B Dankmeyer

7 DATE OF BIRTH (month, day, and year): July 17 1896

8 AGE: Years 58 Months 3 Days 16 If LESS than 1 day, hrs. 15 or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manufacturer of

(b) General nature of industry, business, or establishment in which employed (or employer): Billing-Etc.

(c) Name of employer: Self

BIRTHPLACE (city or town) (State or country): Balto. Maryland

10 NAME OF FATHER: John F. Dankmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Minnie Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Mrs. Evelyn B. Dankmeyer

(Address) 2201 Elsinore Ave.

Filed - 1929 - C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 2 . 29

17 I HEREBY CERTIFY, That I attended deceased from July 29 . 1929 . to Nov 2 . 1929 .

that I last saw him alive on Nov 1 . 1929

and that death occurred, on the date stated above, at 6 45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary): Cardiac deterioration suddenly

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) M Baumanstock M. D.

11/2 . 1929 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park: Sun Burial St Pauls. DATE OF BURIAL: Nov 5 19 29.

20 UNDERTAKER: Stewart Mooney & Co ADDRESS: Balto.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50696

CERTIFICATE OF DEATH

74-006 E 50696

1-PLACE OF DEATH

City of Baltimore: (No. St Joseph's Hospital St. 8-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Giuseppi Giardina

(a) RESIDENCE NO. 2503 E. Oliver Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Clara Rau

6 DATE OF BIRTH (month, day, and year) 4/27.1877

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
52	6	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Frank Giardina

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Ferlitta

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Clara Rau Giardina
(Address) 2503 E. Oliver Street

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/5/29 (Address) 503 E. Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	11 5 1929
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Hanford Av

Important: See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50697

CERTIFICATE OF DEATH. X

11-9-01 E 50697

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 9-17 WARD)

2-FULL NAME Charles G. Edwards

(a) RESIDENCE NO. Patty Hicks Milton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 18 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Widerman

6 DATE OF BIRTH (month, day, and year) 5/1/1872

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
57	6	2	

8 OCCUPATION OF DECEASED Doorkeeper

(a) Trade, profession or particular kind of work Old Town Bank

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 086

(c) Name of employer City Fireman.

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Charles Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Mandy Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Mrs. Mary Edwards (Address) Patty Hicks + Milton

15 Filed 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3/29 19

17 I HEREBY CERTIFY, That I attended deceased from 10/15/29 . 19 . to 11/3/29 . 19 . that I last saw him alive on 11/3/29 . 19 . and that death occurred, on the date stated above, at 12:20A. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) 3 yrs mos ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/2/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S H Barranco M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL 11/6/29

20 UNDERTAKER George J. Ruth — ADDRESS 1035 Hanford

Spec.—2-29-28—L. F. S.—500 Bks.

Tellefson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50698

CERTIFICATE OF DEATH

x 49

E 50698

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sverre Tellefson

(a) RESIDENCE NO. Steamship Margaret ST., WARD Norway

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.... min.
25				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records (Address)

15 Filed 11-5-1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/2/29

17

I HEREBY CERTIFY, That I attended deceased from 9/9 . 1929 . to 11/2 . 1929 that I last saw him alive on 11/2 . 1929 and that death occurred, on the date stated above, at 3:25 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Left Femur.

(duration) yrs. 8 mos. 0 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr. 6, 1929

Was there an autopsy? no

What test confirmed diagnosis? Surgical-Operative Pathological

(Signed) Clifford Poole, M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	11/5 1929
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave

Spec.—8-16-29—L. F. S.—100 Blks.

E 50699 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50699

CERTIFICATE OF DEATH 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2300 Cambridge St. 1-3 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Yetta Rohen (Cohen)

(a) RESIDENCE NO. 2300 Cambridge ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of William Cohen

6 DATE OF BIRTH (month, day, and year) December

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Bernard Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yetta Rosenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

Informant Husband

(Address)

Filed — 1929 H. HAMPSON JONES, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1926 to Nov 4, 1929, that I last saw h[illegible] alive on Nov. 2 - 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Myocarditis

CONTRIBUTORY (Secondary) Rheumatic Endocarditis (duration) 7 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) N. J. Davidor, M. D.

11/6, 19 29 (Address) 3035 McDonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash Road

DATE OF BURIAL 11/5 19 29

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Druid Hill Street

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50700

CERTIFICATE OF DEATH

90 E 50700

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 3801 St Paul ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary B. Parrish

(a) RESIDENCE NO. 3801 St Paul ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

6a If married, widowed, ~~or divorced~~
~~HUSBAND of~~ (or) WIFE of Wm T. Parrish

6 DATE OF BIRTH (month, day, and year) Dec 3/54

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	74	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

BIRTHPLACE (city or town) (State or country) A A Co Md.

10 NAME OF FATHER Richard Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) A A Co

12 MAIDEN NAME OF MOTHER Sarah Koontz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middle Co Md

Informant Wm B Parrish

(Address) 3801 St Paul St

Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 11 1928 to Nov 3rd 1929

that I last saw her alive on Nov 2nd 1929

and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White M. D.

11/4, 1929 (Address) 2808 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 5 1929
20 UNDERTAKER	ADDRESS
George J Smith	Collins

Spec.—2-29-28—L. F. S.—500 Blks.

E 50701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 50701

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Eutaw Place 14-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Palmer White

(a) RESIDENCE NO. 1604 Eutaw Place WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 9 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wesley White

6 DATE OF BIRTH (month, day, and year) Jan. 18, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	9	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER George M. Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Clarke Palmer

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

Informant Mrs. Mary E. Magan

(Address) 1614 Eutaw Place

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1929, to Nov. 3, 1929, that I last saw h[illegible] alive on Nov. 2, 1929 and that death occurred, on the date stated above, at 7.10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (1st attack)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 2nd attack

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jesse S. Kiefer, M. D.

1929 (Address) 162-25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Nov. 5 1929
20 UNDERTAKER	ADDRESS
Wm. J. Ticknor & Sons	17 E. La Cor.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50702 PLACE OF DEATH — 129 E 50702 REGISTERED NO. C

CITY OF BALTIMORE (No. Edgewood Sanatorium 12-50 ST. WARD.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Virginia Parker

(Residence in Baltimore: No. 324 E 22nd ST

St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: July 10, 1860 (Month) (Day) (Year)

7 AGE: 69 yrs. 3 mos. 24 25 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Sales lady
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 067

9 BIRTHPLACE (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): ——

12 MAIDEN NAME OF MOTHER: ——

13 BIRTHPLACE OF MOTHER (State or country): ——

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Barker

(Address) 824 E. 22nd St

15 Filed NOV 5 1929 C. HAMBLETON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 4 (Month) (Day), 1929 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1928, to Nov 4, 1929, that I saw h- alive on Nov 3, 1929, and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

about 8 yrs. mos. d.
(Duration)

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) yrs. mos. d.

(Signed) T. L. Kelly M.D.

Nov 5, 1929 (Address) 1 Wentworth Apts

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death: yrs. mos. ds. In the State: yrs. mos. d.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: WoodLAWN — DATE OF BURIAL: Nov 6, 1929

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St.

IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—8.16.29—L. F. S.—100 Blks.

E 50703

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 50703

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 Dwall Av ST. 15-6 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna W. Lamb

(a) RESIDENCE NO. 3570 Dwall Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eli M. Lamb

6 DATE OF BIRTH (month, day, and year) Dec 27-1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis S. Corcoran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah B. Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ag Burdine Hull

(Address) 3570 Dwall Ave

15 Filed NOV 5 1929 C. H. EMERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1929, to Nov. 4, 1929, that I last saw h.e alive on Nov. 4 1929 and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchi-pneumonia

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination.

(Signed) Morton F. Hofman, M. D.

1929 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friend Cemetery

DATE OF BURIAL Nov. 6 1929

20 UNDERTAKER Chas. E. Franck

ADDRESS 801 Madison Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 50704 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50704

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

City of BALTIMORE: (No. 1531 S. Charles St., 23rd Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Mathilda Rudolph.

(a) Residence No. 1244 S. Charles St., 20th Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single, Married, Widowed, or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced ~~Husband of~~ (or) WIFE of Martin Rudolph.

6-DATE OF BIRTH (month, day and year) Dec 5th-1875

7-AGE. 63 yrs. 10 mos. 28 ds.

If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Matron

(b) General nature of industry, business, or establishment in which employed (or employer) Police Dept.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Michael Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Virginia Stathem

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) William E. Rudolph

(Address) 1531 S. Charles St.

15-

Filed NOV 5 - 1929 H. WILSON JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 11.3.29.

17- I HEREBY CERTIFY, That I attended deceased from 10. 1. 1929 to 11. 3. 1929

that I last saw her alive on 11. 3. 1929

and that death occurred, on the date stated above, at 1.10P m.

The CAUSE OF DEATH* was as follows: Carcinoma of cervix uteri with metastasis involving Vagina, neck of bladder & adjacent structures

(Duration) Days unknown.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Edward Norris, M. D.

11.4.29. (Address) 107 East west St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery	Nov 6th, 1929
20-UNDERTAKER.	ADDRESS
Fred A. Wannemann	203 S. Howard

Spec.—1-10-21—M&T—1500 Bks.

E 50705 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50705

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Portland & Monument STS. 15-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby magaziner

(a) RESIDENCE NO. 2855 W. Harrison Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 29-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~4 weeks~~		1	6	5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Jac Magazine

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Ross Gavonje

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant J. Lewis
(Address) 1739 E Balto. St

15 Filed - 1929 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1929, to Nov. 4, 1929.

that I last saw h~~im~~ alive on Nov. 4, 1929,

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

1 Lobar pneumonia

2

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Anhydremia - acidosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? physical & lab -

(Signed) L. J. Lewis, M. D.

11-5, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem., Mem. Mt. Carmel	11-5 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1739 E Balto St

Spec.—2-29-28—L. F. S.—500 Blks.

E 50706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 50706

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2862 Raynor Ave., ST., 16-68 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mabel A. Filbert

(a) RESIDENCE NO. 2862 Raynor Ave., ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles S. Filbert

6 DATE OF BIRTH (month, day, and year) June 14, 1877

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	52	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Lancaster County, Pa.

10 NAME OF FATHER Marritt L. Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster, Pa.

12 MAIDEN NAME OF MOTHER Louisa Rathforn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

Informant Charles S. Filbert

(Address) 2862 Raynor Ave.,

Filed....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from October 8th. 19 29 to November 1st, 29

that I last saw her alive on November 1st, 29

and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Femoral Thrombosis Gangrene of Leg (duration) yrs. mos. 21 ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. McCandlish M. D.

11/4. 19 29 (Address) 24 W. Fredrick St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	11/5 1929
20 UNDERTAKER	ADDRESS
Wm. Cook	1217 St. Paul

Spec.—8-16-29—L. F. S.—100 Bks.

Dr. Herman 1710 E 33rd St Hun 3489
Residence 2913 E. Fifth St Hug 3818

50707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 801 E 50707

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2119 E Lombard ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie C. Westermann

(a) RESIDENCE NO. 2119 E Lombard ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10th 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Frederick Westermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matilda Westermann
(Address) 2119 E Lombard St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 20 1929, to Nov 3rd 1929, that I last saw h[illegible] alive on Nov 1st 1929 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage.

2

.....(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

.....(duration) ....yrs. 6 mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H Herman, M. D.

11/4/29 (Address) 1710 E 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	11/6 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

St Chas Mem 4085 Pat Ave

E 50708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101 E 50708

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 S Decker Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Edward L Miller Jr

(a) RESIDENCE NO. 829 S Decker Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 3-1915

7 AGE: Years 14 | Months 7 6 | Days 1 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Robt E Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Grace J. Cousins

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

Informant: Robert E Miller

(Address) 829 S Decker St

Filed — — 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 24 1929 to Nov 4 1929

that I last saw him alive on Nov 4 1929 at 2 m.

and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary): Cardiac failure (duration) 2 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at home (duration) yrs. mos. ds.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Ed Duer M. D.

11/4/29 (Address) 4085 Pat Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: Nov 6th 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50709

154-E 50709

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 617 Harwood Ave ST.: ~~Woods~~ WARD

2—FULL NAME Paul Woods

(a) RESIDENCE NO. 617 Harwood Ave ST., WARD Govans

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2hrs. How long in U. S. if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day 2 hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Louis J. Woods

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle R. Rigby

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

Informant Mrs. Louis J. Woods

(Address) 617 Harwood Ave. Govans

Filed 19 Nov 1 Registrar

4032

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929. to Nov. 1, 1929.

that I last saw h[illegible]ive on Nov. 1, 1929

and that death occurred, on the date stated above, at 5:10 p.m.

The CAUSE OF DEATH* was as follows:

Non closure of foramen ovale

(duration) yrs. mos. 2 hours

CONTRIBUTORY (Secondary) Premature baby - 5 months

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Guy V. Root M. D.

19 (Address) 3957 Greenmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: NOV 5 - 1929

20 UNDERTAKER: [illegible] Bureau of Vital Statistics

ADDRESS

Dep. Com. of Health.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 50710

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7 So. Caroline ST. 3-4 WARD)

2—FULL NAME Luella Davis

(a) RESIDENCE NO. 7 So. Caroline ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

10 NAME OF FATHER Edward Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

Informant Lucie Collins

(Address) 7 So Caroline St

Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4-29

17

I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929 to Nov 2, 1929

that I last saw h.. alive on Nov 2, 1929

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Lobar Pneumonia

(duration) yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs,

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. A. Bolden, M. D.

11-4, 1929 (Address) 610 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem.	11-5 1929
20 UNDERTAKER	ADDRESS
Bryan & Wright	218 E Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

E 50711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

78 V

E 50711

1—PLACE OF DEATH Baltimore City Hospitals 26-27 REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST., ____ WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Bailey

(a) RESIDENCE NO. 628 Newkirk St. ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of → George E. Bailey, ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER William Byurm

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929 to Nov. 4, 1929.

that I last saw her alive on Nov. 4, 1929

and that death occurred, on the date stated above, at 1:20 A. m.

The CAUSE OF DEATH* was as follows:

Epilepsy (Undetermined Nature)

(duration) 5 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Status Epilepticus

(duration) ____ yrs. ____ mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist PC

(Signed) Warren McM^c Lam, M. D.

11-4, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov 7 1929
20 UNDERTAKER Lilly Julian Shue	ADDRESS 4033 E. Monument St

Spec.—2-29-28—L. F. S.—500 Blks.

ROSSMARCK ✓

E 50712 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 50712

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hosp. Baltimore Md. REGISTERED NO.

CITY OF BALTIMORE: (No. U. M. H., Balto. Md. ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. John G. Rossmarck

(a) RESIDENCE NO. 714 E. 35th St. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 11 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary Eliz. Benjamin

6 DATE OF BIRTH (month, day and year) Aug 21, 1845.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
84	11 2	14 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) City, Baltimore

10 NAME OF FATHER George Rossmarck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Henry T ... Daughter

(Address)

Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929, to Nov. 4, 1929, that I last saw him alive on Nov. 4, 1929, and that death occurred, on the date stated above, at 3.50 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate.

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Arterionabrain with hypertension

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Samuel McCausland, M. D.

Nov 4 1929 (Address) Union Mem. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	11/7/1929
20 UNDERTAKER	ADDRESS
Geo. W. Rue & Son	3503 Edmondson Ave

DEC 5 1929 C. HAMSON JONES

Cor.—10-10-29—A Co.—100 Bks.

E 50713

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50713

CERTIFICATE OF DEATH

1-PLACE OF DEATH Univ Hosp

City of Baltimore: (No. 1148 Longwood St.) 16-67 188-103 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Wilson Rich

(a) RESIDENCE NO. 1148 Longwood St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Rich

6 DATE OF BIRTH (month, day, and year) Sept 25 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) obb
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Bradford Rich

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna R Rich

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Anna R Rich
(Address) 3905 Leliston Ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract of tibia L mid evulsion of post Part
Struck & knocked down by auto

CONTRIBUTORY (Secondary) Traumatic (Surgical) shock (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pratt no Hanover

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr J. Clement

(Signed) J Brann M. D.

11/4 19 29 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL Nov 6 1929

20 UNDERTAKER John O Mitchell & Son — ADDRESS 1900 Eutaw Place

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50714

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50714

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 Elmira ave. 25-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry L. Lathe

(a) RESIDENCE NO. 2200 Elmira ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~ or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 24 1926.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Lathe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alva Gaston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thomas Lathe (Address) 2200 Elmira ave.

15 Filed ..., 19 C. HAMPSON HOWARD, M.D. Registrar

NOV 5 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 3, 1929, that I last saw him alive on Nov 3, 1929, and that death occurred, on the date stated above, at 6/0 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) no yrs. no mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) R V Gilman, M. D.

Nov 4. 1929 (Address) 2708 Hollins Ferry Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Dalto Cem.	11/6 1929
20 UNDERTAKER Edward Foulon	ADDRESS 2359 Wilkens ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50715 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50715

CERTIFICATE OF DEATH 31

1—PLACE OF DEATH Baltimore City Hospitals (F.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Caruso

(a) RESIDENCE NO. 937 Madison ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Caruso

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Aaron Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed NOV 5 - 1929, 19 C. HAMILTON JOHNSON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1929, to Nov. 3, 1929, that I last saw her alive on Nov. 3, 1929 and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Pierce Jr. M. D.

11-4-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cem	11-5-29
20 UNDERTAKER Daniel Easton	ADDRESS 916 Ba ave

E 50716

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50716

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital 74-001

CITY OF BALTIMORE: (No. 1000 Caton Ave ST., 6 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Costello

(a) RESIDENCE NO. 2013 Orleans ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Costello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rosanna Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Jenkins Memrial Hosp
(Address) 1000 Caton Ave

15 Filed NOV 5 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to Nov. 2, 1929, that I last saw her alive on Nov 2, 1929, and that death occurred, on the date stated above, at 9-15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

. 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Nov. 6 19 29

20 UNDERTAKER William G Schaeffer — ADDRESS 1816 Monument

Cor.—10-10-29—A Co.—100 Blks.

E 50717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50717

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp. St. 21-44 Ward)

2-FULL NAME Mrs. Mary F. Mohr

(a) RESIDENCE NO. 2706 Pinckney St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	wid

5a If married, widowed, or divorced (or) WIFE of Rev H. O. Mohr

6 DATE OF BIRTH (month, day, and year) Jan 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68	10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Pa
(State or country)

PARENTS

10 NAME OF FATHER Jacob Stuck

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hart

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Fr. Mother
(Address) 308 S. Ellwood Ave

15 Filed 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Acute Cardiac Dilatation

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Perry M. D.

Nov. 1929 (Address) 1029 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Pa — DATE OF BURIAL 11/6/1929

20 UNDERTAKER J. G. Logan — ADDRESS 302 E. Baltimore

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 50713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 50713

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora A. McClintock

(a) RESIDENCE NO. 313 N. Broadway St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 28 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) March 6, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	67	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: 668

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Winfield McClintock

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary McMahon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Sue McClintock
(Address) 313 N. Broadway

15 Filed 19 C. HAMPSON JONES, M. D. Registrar
- 1929 Pm

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature]

11-5-29 (Address) 505 E. North Ave M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 11/7 19 29

20 UNDERTAKER: Henry W. Mears, Inc. Son

ADDRESS: 805 N. Calvert

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

D. W. W. White Jr
Physician Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50719

CERTIFICATE OF DEATH

90 E 50719

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 N. Spring ST. 9-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Janet Wilson

(a) RESIDENCE NO. 1522 N. Spring ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Wilson

6 DATE OF BIRTH (month, day, and year) Apr 6th 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Annie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant William H Wilson

(Address) 1522 N. Spring St

15 Filed Nov 9, 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 12, 1929, to Nov 4, 1929, that I last saw her alive on Nov 4, 1929 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

1a Myocarditis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W W White Jr, M. D.

11/5, 1929 (Address) 2802 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 7th 1929
20 UNDERTAKER	ADDRESS
Wm Cook	127 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50720

CERTIFICATE OF DEATH

31

E 50720

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 Loudon Ave 20-11 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George J Peters

(a) RESIDENCE NO. 140 Loudon Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 3 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

7a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Peters

6 DATE OF BIRTH (month, day, and year): July 26 1878

7 AGE — Years: 51 | Months: 3 | Days: 9 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Packer. 056

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: George J Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore.

12 MAIDEN NAME OF MOTHER: Ellen Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

Informant: Mrs Thelma Meeks

(Address) 140 Loudon Ave.

Filed NOV 6 1929, 19 — H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 5/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1928, to Nov 5, 1929, that I last saw h[illegible] alive on Nov 3, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 5 yrs 6 mos ds.

Endocarditis (duration) 2 yrs mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. J. Emory M. D.

11/6/29 (Address) 6 W Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Nov 7th 1929

20 UNDERTAKER: John J Cannon & Son

ADDRESS: 901 Hollins St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5072E

CERTIFICATE OF DEATH

74 001

E 50721
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) University Hospital St., (Ward) 16-9

2-FULL NAME Vincent Machis

(a) RESIDENCE NO. 867 Hollins St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella Machis

6 DATE OF BIRTH (month, day, and year) Nov 1-1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	48		3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Matthews Machis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Mrs Ella Machis
(Address) 867 Hollins St

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 4. 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY
(Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

11/5. 1929. (Address) 270 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	nov 7 19 29
20 UNDERTAKER	ADDRESS
John F. Cowan & Son.	[illegible]

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50722

CERTIFICATE OF DEATH

118-002 E 50722

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mervin Chase

(a) RESIDENCE NO. 1510 N Mount ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Ofc
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Samuel Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Chase
(Address) 1622 W Franklin

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-29

17 I HEREBY CERTIFY, That I attended deceased from 11-2, 19 29, to 11-3, 19 29
that I last saw h alive on 11-3, 19 29
and that death occurred, on the date stated above, at 9.15 P. m.
The CAUSE OF DEATH* was as follows:
Intestinal Obstruction
Post operative)

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Toxemia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? yes Date of 11-3-29
Was there an autopsy? no
What test confirmed diagnosis? Exploratory Laparotomy
(Signed) Bernard Harris M. D.
11-4, 19 29 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Lebanon	Nov 7 1929
20 UNDERTAKER	ADDRESS
Joseph A Lively	1098 N Mount St

Spec.—2-29-28—L. F. S.—500 Bks.

E50723 HEALTH DEPARTMENT—CITY OF BALTIMORE E50723

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 409 N Gilmor ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mitchell Hongus

(a) RESIDENCE NO. 409 N Gilmor ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): M.

6 If ~~married~~, widowed or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Jane Hongus

6 DATE OF BIRTH (month, day, and year) March 21-1860

7 AGE: Years 69 | Months 7 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dorchester Co Md

10 NAME OF FATHER: William Hongus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

Informant: Emma Dixon

(Address) 409 N. Gilmor

Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 . 1929. to Nov 5 . 1929.

that I last saw him alive on Nov 4 1929

and that death occurred, on the date stated above, at 12 46 9 m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Carey, M. D.

11 5, 1929 (Address) 1715 Mt Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dong. Mt Carmel Cemetery Md

DATE OF BURIAL: Nov. 6 1929

20 UNDERTAKER: Sam'l M. Chase & Son

ADDRESS: 1400 Mosher

Cor.—10-10-29—A Co.—100 Bks.

E 50724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 ✓ E 50724

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Enroute Hopkins Hospital St. 5-8 Ward)

2-FULL NAME Joseph C. Nolte

(a) RESIDENCE NO. 1500 E. Balto St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ~~Child~~

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) 059
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER J. Nolte

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John Nolte
(Address) Central Av. & Jefferson St.

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

11/6/29 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	11/6 19 29

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Rks.

E 50725 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50725

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) 15-21 ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Hornstein

(a) RESIDENCE No. 1814 W. North ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE white

5 Single, Married, Widowed, Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Hornstein

6 DATE OF BIRTH (month, day, and year) Dec. 1859

7 AGE Years 69 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levin (Address) 1439 E. Baltimore

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1929, to Nov 5, 1929, that I last saw him alive on Nov. 5, 1929, and that death occurred, on the date stated above, at 4.48 p m.

The CAUSE OF DEATH* was as follows:

generalized arteriosclerosis

Chr. Encephalitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unk

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical history

(Signed) J. H. Conn, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Cem

DATE OF BURIAL 11/6 19 29

20 UNDERTAKER Jack Levin 1439 E Balt St

ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

E 50726

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50726

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1635 N Bentalou ST. 15-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bert Daniel Pitcher

(a) RESIDENCE NO. 1635 N Bentalou ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs.— mos.— ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellora Pitcher

6 DATE OF BIRTH (month, day, and year) July 10 74

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) O'S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS

10 NAME OF FATHER E Pitcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER E Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs E Ellora Pitcher

(Address) 1635 N Bentalou

15 Filed ..... 19 .....

NOV 6 - 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 2 19 29 to Nov 4 19 29, that I last saw him alive on Nov 4 19 29 and that death occurred, on the date stated above, at 11.45 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 da.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. V. Zeiler, M. D.

Nov 7. 19 29 (Address) 207-8- Medical Arts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Nov 6 1929
20 UNDERTAKER	ADDRESS
W M Routson	2235 N Mont

Spec.—2-29-28—L. F. S.—500 Blks.

E 50727

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50727

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 15662

CITY OF BALTIMORE: (No. 3700 Dorchester WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abraham Spear

(a) RESIDENCE NO. 3700 Dorchester ST. Rd. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Spear

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Isaac Spear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Belle Bachrach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Irving Spear

(Address) 3700 Dorchester Rd

15 Filed NOV 6 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-4-29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1922, to Nov. 4, 1929 that I last saw h[illegible] alive on Nov. 4th. 1929 and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial dilitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical exam

(Signed) Eugene Shepard, M. D.

(Address) 200 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balt. Hebrew Cem.	11/6/1929
20 UNDERTAKER David Sondheim	ADDRESS 1520 W. Mt Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50728

CERTIFICATE OF DEATH

84 ✓ E 50728

1—PLACE OF DEATH

REGISTERED NO. 27-55

CITY OF BALTIMORE: (No. 3805 Hayward Avenue ST., ____ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Margaret Rosensteel

(a) RESIDENCE NO. 3805 Hayward Avenue ST., ____ WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 10 mos. 3 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	10	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Walter G. Rosensteel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Minna M. Thornton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

Informant Walter G. Rosensteel

(Address) 3805 Hayward Avenue

Filed ____, 19 ____ For ____ Registrar

C. HAMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from ____, 19 29 to Nov 4, 19 29

that I last saw h[illegible] alive on Nov 4, 19 29

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Diplegia.

(duration) life time yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Thrombosis

(duration) ____ yrs. ____ mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Chubrich, M. D.

(Address) 11 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	11/7 19 29
20 UNDERTAKER	ADDRESS
Henry U. Mears & Son	805 N. Calvert St.

Cor.—12-9-25—A Co.—200 Blks.

E 50729

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 50729

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 27-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Schultz

(a) RESIDENCE NO. 2904 Gindon Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Rose Schultz

6 DATE OF BIRTH (month, day, and year) Nov 18 72

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	56	11	17	16.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Commission

(c) Name of employer Merchant

9 BIRTHPLACE (city or town) _____

(State or country) City

PARENTS

10 NAME OF FATHER John Schultz

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Md.

14 Informant Rose Schultz

(Address) 2904 Gindon Ave

NOV 8 - 1929

Filed _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said _____ (Inquest, autopsy or inquiry.) find that said deceased came to _____ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cor. Art. Heart

Sudden (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ M. D.

(Coroner)

Nov 7 1929 (Address) 659 Brooks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs., ____ mos., ____ ds. In the State ____ yrs., ____ mos., ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — Date of Burial Nov 7 1929

20 UNDERTAKER Philip J Henry — ADDRESS 2016 Orleans

Key important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks. 111

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50730

CERTIFICATE OF DEATH

84 ✓ E 50730

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1729 Olive ST. 23-32 (WARD)

2—FULL NAME Luther N Deter

(a) RESIDENCE NO. 1729 Olive ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. de. How long in U. S., if foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Deter

7 DATE OF BIRTH (month, day, and year): June 4 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Jacob Deter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

Informant: Mary Deter

(Address) 1729 Olive St

Filed 11-6, 1929 CHARLES E. HAMPE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-4-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Nov 4, 1929

that I last saw him alive on Nov 4, 1929

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Testis

Indefinate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R E Campbell M. D.

Nov 5, 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	11-6 1929
20 UNDERTAKER	ADDRESS
E I B Harle	115 E West St

Spec. 2-29-28—L. F. S.—500 Blks.

E 50731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 1001 E 50731

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917 Shirley Ave St. 27-4th WARD) Hamilton

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophia R Evans.

(a) RESIDENCE NO. 2917 Shirley Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

7a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joshua A Evans

6 DATE OF BIRTH (month, day, and year): Sept 23 1841

7 AGE: Years 88 | Months 1 | Days 13 1/2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Henry Hedeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Mrs J Norris Bramble

(Address) 2917 Shirley Ave

V6 - 1929 Filed HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-5th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 28th 1929 to Nov 5th 1929.

that I last saw her alive on Nov 4th 1929

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

(duration) yrs 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F C McGinnis M. D.

Nov. 5 1929 (Address) Gwynns Falls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 11-7 1929

20 UNDERTAKER: Mrs Chas A G Rohde — ADDRESS: 2327 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 E 50732

E 50732

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 333 Presstman ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME New born (Infant Moore)

(a) RESIDENCE NO. 333 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2 1929

7 AGE — Years — Months — Days 1 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Ernest Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester Va

12 MAIDEN NAME OF MOTHER Elizabeth Asbur

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Columbia S.C.

14 Informant Ernest Moore

(Address) 333 Presstman St.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1929, to Nov 3, 1929, that I last saw h[illegible] alive on Nov 3, 1929 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows: Acute Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) Luther T. Gault, M. D.

, 19 (Address) 113 W Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Interment Baltimore Cemetery — DATE OF BURIAL: 11-6 1929

20 UNDERTAKER: George P. A. Gibson — ADDRESS: 1735 Druid Hill Ave

FRANCIS T. STEWART, M. D. SANITARY OFFICER, BALTIMORE CITY HEALTH DEPARTMENT

Spec.—1-10-21—M&T—1500 Bks.

E 50733

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 √E 50733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2404 Montebello Ter.

CITY OF BALTIMORE: (No. 2404 Montebello Ter. ST., 27 WARD) 27-44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W. Jones

(a) RESIDENCE No. 2404 Montebello Ter. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Jones

6 DATE OF BIRTH (month, day, and year) January 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	20	28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work waiter 0/0

(b) General nature of industry, business, or establishment in which employed (or employer) Dining room waiter

(c) Name of employer B&O. Railway Co.

9 BIRTHPLACE (city or town) Anne Arundel Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Isaac Jones

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Martha Sipes

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Eliza Jones

(Address) 2404 Montebello Ter

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) √ Nov. 19 29 √

17

I HEREBY CERTIFY, That I attended deceased from 14 Aug. 19 29 to √ Nov. 19 29.

that I last saw h[illegible] alive on 4 Nov 19 29.

and that death occurred, on the date stated above, at 2 a.c. m.

The CAUSE OF DEATH* was as follows:

Cancer of the sigmoid

(duration) over 6 yrs. mos — ds.

CONTRIBUTORY (Secondary) nil (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 31 Aug 29

Was there an autopsy? No. What test confirmed diagnosis? None.

(Signed) Bamfield Bell M. D.

(Address) 5126 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 11/6/ 1929

UNDERTAKER Wm. Geo. H. Holland — ADDRESS 1661 Druid [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50734

100-001

CERTIFICATE OF DEATH

E 50734

1—PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division ST. 21-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Dixon

(a) RESIDENCE NO. 810 S Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Aug 6. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) odd

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md (State or country)

10 NAME OF FATHER George Dickson

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Clarissa Boyd

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Ina M. Dixon Mother

(Address) 810 S Fremont Ave

15 Filed ....., 19.... C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Nov 3, 1929, that I last saw him alive on Nov 3 1929 and that death occurred, on the date stated above, at 3 50 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Primary)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted, if not at place of death? Residence

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

11-3, 1929 (Address) 3 S Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Nov 6, 1929
20 UNDERTAKER	ADDRESS
Joseph A Lively	409 N. Mont St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50735 ✓ E 50735

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3441 Guilford Terrace ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Parkins Buck

(a) RESIDENCE NO. 3441 Guilford Terrace ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 83 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel D. Buck

6 DATE OF BIRTH (month, day, and year): About 1846

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
About 83	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of indostry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Winchester Virginia

PARENTS

10 NAME OF FATHER: Joseph Parkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Winchester Virginia

12 MAIDEN NAME OF MOTHER: Helen Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bucklon Virginia

14 Informant: Mr John G Buck

(Address): 344 Guilford Terrace

15 Filed: V 6 - 1929 Date

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-5-29

17 I HEREBY CERTIFY, That I attended deceased from 11-1-29, to 11-5-29, that I last saw her alive on 11-4-29, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

LOBAR PNEUMONIA

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: Nov 7 1929

20 UNDERTAKER: Stewart & Co

ADDRESS: Baltimore

Spec.—1-12-23—M&T—500 Bks.

E 50736 ✓ E 50736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 S Ann St ST. D-4 WARD)

2-FULL NAME Anna Rachuba

(a) RESIDENCE NO. 723 S Ann St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~Husband's Name~~ (b) WIFE of Andrew Rachuba

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 37 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Szymon Ratajczak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Andrew Rachuba 723 S Ann St

15 Filed ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Nov 4 1929, that I last saw h[illegible] alive on Nov 4, 1929, and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What tests confirmed diagnosis? —

(Signed) William J. Rykowski M. D.

(Address) 1001 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus cemetery

DATE OF BURIAL Nov. 8 1929

20 UNDERTAKER George A Weber

ADDRESS 705 S Ann

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50737

CERTIFICATE OF DEATH

17° E 50737

1-PLACE OF DEATH

City of Baltimore. (No. Highland & Fennimore 6-10 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carol I. Drublen

(a) RESIDENCE NO. 403 N Lakewood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 1907

7 AGE: Years 22 | Months 7 | Days 14 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Collector
(b) General nature of industry, business, or establishment in which employed (or employer) Drugs
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER John Drublen

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Neuberger

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Mrs. John Drublen (Address) 403 N. Lakewood

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Gun Shot Wound of Chest
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Internal Hemorrhage
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? — Was —

What test confirmed diagnosis?

(Signed) J. C. Grades, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balt Redeemer | DATE OF BURIAL Nov. 7 1929

20 UNDERTAKER Jos. J. Kerr | ADDRESS 156 N. Luzerne

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

2 3 E 23 50738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 50738

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Killmeyer

(a) RESIDENCE NO. 1806 Hennenman St. Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-2-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Jaul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kooget

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant ....(Address) JOHNS HOPKINS HOSPITAL Records

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Nov 5, 1929, that I last saw h.a.m. alive on Nov 5, 19 29 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

4 yrs 5 months (duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Bickland Jr., M. D.

11/6, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Nov. 7 1929

20 UNDERTAKER Chas E Crackon Inc

ADDRESS 1701 Maryland

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50739

CERTIFICATE OF DEATH

38 E 50739

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 10-14 WARD)

2—FULL NAME Cotaldo Scarpello

(a) RESIDENCE NO. 1117 Proctor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): Jan 6. 1870

7 AGE: Years 59 | Months 10 | Days 0 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Presser

(b) General nature of industry, business, or establishment in which employed (or employer): clothing

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Italy

10 NAME OF FATHER: Peter Scarpello

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown Sicily

12 MAIDEN NAME OF MOTHER: Pellegrino Penna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Sicily

Informant: Mt Hope Friends

(Address): Mt Hope Retreat

Filed ....., 19 .....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 6. 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1924, to Nov 6, 1929, that I last saw him alive on Nov. 3, 1929 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis

unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chr. myocarditis

unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Kahn

(Signed) Milton P. Fell, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 8 1929

20 UNDERTAKER: Chas. T. Broadbent & Son 1900 Eutaw — ADDRESS: Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50740

E 50740

CERTIFICATE OF DEATH

161-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1021 Rice St. 18-23 Ward)

2-FULL NAME Mariam Williams

(a) RESIDENCE NO. 1021 Rice St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fml	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 08-27-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Walter Williams

11 BIRTHPLACE OF FATHER (city or town) West Indies
(State or country)

12 MAIDEN NAME OF MOTHER Anna Johnson

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Anna Williams
(Address) 1021 Rice St

15 Filed ..... 19.. Registrar

4036 MCH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, and find that said deceased came to her death
(autopsy or inquiry)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth
(7 months child)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. Leutch, M. D.
Nov 5 1927 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

C. HAMPSON JONES, M.D.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 50741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 129

E 50741

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 N. Eutaw Ave ST. 8-16 WARD)

2-FULL NAME Annie R Marck

(a) RESIDENCE NO. Baker Ave Fullerton md ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1864

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	65		17	16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward Spurrier

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Eleanor Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Otto Marck
(Address) Baker Ave Fullerton

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.
1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3 1929 to Nov. 6 1929.

that I last saw h er alive on Nov. 5 1929

and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Cardio - vascular - renal disease.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Schmit, M. D.

11/6, 1929 (Address) 701 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 8 1929
20 UNDERTAKER	ADDRESS 153
F. Vernon Keehner	Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50742

CERTIFICATE OF DEATH

21-001 ✓ E 50742

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernard Braun

(a) RESIDENCE NO. 765 W. Lexington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 24, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9	12	11

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James Braun

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Susan Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

Informant James Braun

(Address) 765 W. Lexington St

Filed ..... 19 .....

C. HAMPSON JONES, M. D.

1929 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929 to Nov 5, 1929, that I last saw h[illegible] alive on Nov 5, 1929 and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis (Friedlander Bacillus Typed)

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duratinn) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 765 W Lexington St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & X ray

(Signed) Addison Craft Wk, M. D.

11-6 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 7 1929
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

Spec.—1-10-21—M&T—1500 Blks.

H E 50743

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50743

CERTIFICATE OF DEATH

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St. or Ward) 4-17-118-02

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Mitchell

(a) RESIDENCE NO. Colgate Md St., WARD Back River Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Octavia Mitchell

6 DATE OF BIRTH (month, day, and year) Oct 18-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	0	18	17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mrs Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Octavia Mitchell (Address) Bland & Eastern Ave

15 Filed - 1929, 19 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Nov. 5, 1929, that I last saw h[illegible] alive on Nov 5, 1929, and that death occurred, on the date stated above, at 7[illegible] m.

The CAUSE OF DEATH* was as follows:

Intestional Obstruction (mechanical)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary embolism

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Nov 5, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) V. Megnon, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Nov

DATE OF BURIAL 8 1929

20 UNDERTAKER John C. Miller

ADDRESS 245 E. Oliver

Spec.—1-29-26—L. P. S.—500 Blks.

E 50744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50744

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor 40-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Kelly

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Boston Mass.
(State or country)

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Anna Griffin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley Sts

15 Filed 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1929, to Nov 7 1929, that I last saw h alive on Nov 6 1929, and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

CONTRIBUTORY (Secondary) Oedema of Lungs (duration) 1 yr mos ds.

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Simmons Wells, M. D.

11/6. 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Nov 7. 1929

20 UNDERTAKER Rita Wiedefeld ADDRESS 914 Gressum Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50745 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50745

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 13-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa Spencer

(a) RESIDENCE NO. 4711 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

7 DATE OF BIRTH (month, day, and year): 1877 -

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: Richard H Edmunds

BIRTHPLACE (city or town) (State or country): Ga -

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

Informant: Richard H. Edmunds

(Address) 4711 Roland Ave

Filed ..... 19 OCT 11

6 - 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to Nov. 6, 1929, that I last saw her alive on Nov 6, 1929 and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

acute appendicitis, with abscess

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 22, 1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George H Yeager, M. D.

11-6, 1929 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Macon Ga	Nov 6 19 29
20 UNDERTAKER	ADDRESS
Samuel Wensley	Baltimore

C. HAMPSON JONES, M.

Cor.—10-10-29—A Co.—100 Blks.

E 50713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3E 50746

1-PLACE OF DEATH U. S. Marine Hospital

City of Baltimore: (No. 17-51 St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ole Mortensen.

(a) RESIDENCE NO. Unknown St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1903

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
26	1	7	5

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ss Lavade

9 BIRTHPLACE (city or town)
(State or country) Norway

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Hospital Records
(Address) U. S. Marine Hospital

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Mortensen M. D.

Nov. 1929 (Address) 3622 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's, Hampden	Nov. 7, 192
20 UNDERTAKER E. Leroy Stiffler, Inc.	ADDRESS 125 E. North Ave.

E. Leroy Stiffler, Inc.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50747

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Gator ave. 40-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa J. Standiford

(a) RESIDENCE NO. 616 Gator ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles R. Standiford

6 DATE OF BIRTH (month, day, and year): July 17, 1853

7 AGE: Years 76 | Months 3 | Days 19 | If LESS than 1 day, hrs. or min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

10 NAME OF FATHER: Conrad Gunther

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Julia Stengle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

Informant: Miss Gunther

(Address) 616 E Gator Ave.

Filed ..... 19 ..... HAMPSON JONES, M. D.

1929 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mr 5-29

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1928, to Mr 5, 1929, that I last saw h alive on Mr 4, 1929 and that death occurred, on the date stated above, at 4.55 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, a. el Nephritis

Ch Myocarditis

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary): Ant cardiac dilatation

(duration) yrs. mns. 10 ds.

18 Where was disease contracted if not at place of death? Sam

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) B W. Bishop, M. D.

Nov. 1929 (Address) 501 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ebenezer, Harford Co. Md.

DATE OF BURIAL: Nov 7, 1929

20 UNDERTAKER: E Leroy Stiffler, Inc

ADDRESS: 125 E North Ave.

Spec.—1-10-21—M&T—1500 Blks.

E 50748

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 E 50748

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen. Hosp. WARD) 28-63

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Bunting Morton

(a) RESIDENCE No. 3905 Fern Dale Ave ST., WARD "H."

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Zola Kansler Morton

6 DATE OF BIRTH (month, day, and year) July 20, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 466

(c) Name of employer Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Robt. C. Morton Sr

11 BIRTHPLACE OF FATHER (city or town) Phila. Pa (State or country)

12 MAIDEN NAME OF MOTHER Minna Crum

13 BIRTHPLACE OF MOTHER (city or town) Balti (State or country) Md.

14 Informant Dau. Records. (Address)

15 Filed 7-1929 . 19 C. HAMPTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-3- . 1929, to 11-5- . 1929, that I last saw him alive on 11-5-29 . 19 , and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows: Mesenteric Thrombosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 11-4-29

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) J. Robert Miller M. D.

11/5 29 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Nov. 8 1929

20 UNDERTAKER Joseph Cook

ADDRESS 1003 West Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

Pruiet.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 50749

E 50749

CERTIFICATE OF DEATH.

2-6-37 57

REGISTERED NO

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Pruiet

(a) RESIDENCE NO. 313 S. Coulbourn ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Pruiet

6 DATE OF BIRTH (month, day, and year) Sept. 26, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph S. Cramblitt

11 BIRTHPLACE OF FATHER (city or town) Ellicott City
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ellen Hamilton.

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City
(State or country) Maryland

14 Informant Mrs. Eleanora Weeks
(Address) 3435 Leaverton Ave.

15 Filed OCT 7 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Nov. 5, 1929, that I last saw h e alive on Nov. 4, 1929, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Pyelonephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood culture & autopsy

(Signed) J. E. Eyerdman, M. D.

11/13/29 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oella Cemetery

DATE OF BURIAL Nov. 8 1929

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St.

Cor—12-9-26—A Co.—200 Blks.

E 50750

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

103
188 E 50750

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital, 22 W. 30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Morriss

(a) RESIDENCE NO. 819 S Paca. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4 1927

7 AGE	Years	Months	Days 2	IF LESS than 1 day.....hrs. or.....min.
	2	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm. Morriss

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Eth[illegible] Dunn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Wm. Morriss

(Address) 819 S Paca St

15 Filed 11-7 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fract Skull
Run down by automobile
in middle of Intersection

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Extra Dural Hemorrhage

(Duration) yrs. mos. ds.

(Signed) J H Haine M. D.
(Coroner)

11/6 1929 (Address) 2939 Mt Elden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Paca & Conway Sts

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wellington Md. Date of Burial 11-8 1929

20 UNDERTAKER Bernard Hale ADDRESS 1021 Pierce St

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-081 E 5075[illegible]

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Druid Hill ST. 724 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pauline Johnson.

(a) RESIDENCE NO. 706 Druid Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonas.

6 DATE OF BIRTH (month, day and year) 1890

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid. 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. D.C.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washdc

14 Informant Amos Johnson (Address) 706 Druid Hill

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 5-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 23 1929 to Nov 5th 1929 that I last saw h[illegible] alive on Nov 5th 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension & Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Regula Heilpern, M. D.

Nov 6, 19 (Address) 1006 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	11-7 1929

20 UNDERTAKER David Taylor ADDRESS 916 Pa ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50752

CERTIFICATE OF DEATH

31 ✓ E 50752

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 22-33 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Smith

(a) RESIDENCE NO. 20 E. Churchill st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unkn yrs. 0 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Andrew Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Virginia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed 7-1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1929, to Nov. 5, 1929,

that I last saw h. im alive on Nov. 5, 1929

and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Gunn M. D.

11-5, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cem	11/8 19 29
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Pa Ave.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50753

CERTIFICATE OF DEATH.

✓44 E 50753

1-PLACE OF DEATH

City of BALTIMORE: (No. Carters Sanitarium 23-34 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emilie Garthe Bellona avenue

(a) RESIDENCE NO. 3 E. Randell St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christian Garthe

6 DATE OF BIRTH (month, day, and year): Feb 4 1847

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	82	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Andreas Gerke

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Baltz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Henry G. Garthe

(Address): 3403 Copley Road.

15 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

November 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929 to Nov 5, 1929, that I last saw her alive on Nov 5, 1929, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows: Cancer of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted —

If not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ed. L. Zimmerman, M. D.

Nov 5 1929 (Address) 6858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: Nov 8 1929

20 UNDERTAKER: Fred A. Krauserson — ADDRESS: 703 E. Hoffman

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50754

CERTIFICATE OF DEATH.

3 1 E 50754

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3113 Cliftmont Ave ST., 26-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Virginia Lee

(a) RESIDENCE NO. 3113 Cliftmont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~of~~ Jessie B Lee Widowed ~~Nov 4 1923~~

6 DATE OF BIRTH (month, day, and year) Dec. 25 1872

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Kissner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Jemima Gorman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) John Lee 3113 Cliftmont ave

15 Filed ..... 19 ..... Registrar

- 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 4 1929

17

I HEREBY CERTIFY, That I attended deceased from May, 1929, to November, 1929, that I last saw h[illegible] alive on Nov. 4, 1929, and that death occurred, on the date stated above, at 345 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) Joseph Pokorny M. D.

19 (Address) 2200 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 11/7/29

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50755

CERTIFICATE OF DEATH

75-002
E 50755

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4804 Park Heights Ave. ST., 47-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Kate H Briggemann

(a) RESIDENCE NO. 4804 Park Heights Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 8 mos. 12 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Briggemann

6 DATE OF BIRTH (month, day, and year): Feb 24, 1856

7 AGE: 73 Years | Months 8 | Days 11 | If LESS than 1 day, ...hrs. or ....min. 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. md

10 NAME OF FATHER: Samuel Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth Beal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Raymond Briggemann

(Address): 1814 W Lexington St 21

15 Filed ....., 19 - 1929

16 ....., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1927, to Nov 5th 1929, that I last saw her alive on Oct 29th, 1929 and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(duration) 2 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical Exam.

(Signed) L. B. Turner, M. D.

11-5. 1929 (Address) 4936 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — DATE OF BURIAL: 11/7/1929

20 UNDERTAKER: Geo. W. Best & Son — ADDRESS: 2503 Edmondson

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50756 — 188-203 — E 50756

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hospital St., Ward)

2-FULL NAME Chas Long

(a) RESIDENCE NO. Ruxton Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) July 25-1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	22	3	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor
(c) Name of employer Carroll Hinton

9 BIRTHPLACE (city or town) Lochraven
(State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Robt Long

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Hattie Hutton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Robert Long
(Address) Ruxton Md

15 Filed NOV 7 1929 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus
due Down by auto while
walking along road
(second to appendectomy)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute dilitation
Stomach
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ruxton

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical +

11/17, 19 29 (Signed) P. J. France, M. D.
(Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Chestnut Ridge	Nov 9 1929
20 UNDERTAKER	ADDRESS
Wm C Bowler & Son	Sparks, Md

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 50757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50757

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 640 Gutman (ST.) 9-46 (WARD)

2—FULL NAME Catherine G. Bormuth

(a) RESIDENCE NO. 640 Gutman ave (ST.) (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 7 mos. 9 ds. How long in U. S., if foreign birth? Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Joseph A. Bormuth

6 DATE OF BIRTH (month, day, and year) March 26 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. John P. Bormuth

(Address) 640 Gutman Ave.

15 Filed NOV 7 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 5 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 28, 19 29, to Nov 5 29, 19 29, that I last saw her alive on Jan 5 29, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Endocarditis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Chronic Coronary Sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo. Yeargotmyo III D., M. D.

11/6, 1929 (Address) 401 E 25-72 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Nov. 8 1929

20 UNDERTAKER Henry Hoech & Sons Inc.

ADDRESS 1301 E Eager St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50758

CERTIFICATE OF DEATH

74 E 50758

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 932 E. Chase ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret A. Farrelly

(a) RESIDENCE NO. 932 E. Chase ST., WARD

(Usual place of abode) 4mo

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if foreign birth? 45 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Michael J. Farrelly

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael McCabe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Miss Margaret V. Farrelly

(Address) 932 E Chase St

15 Filed 7-1929 C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 5 - 1929

17 I HEREBY CERTIFY That I attended deceased from Oct 15, 1929 to Nov 5, 1929 that I last saw her alive on November 5, 1929 and that death occurred, on the date stated above, at 7.45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis X hypertension (duration) — yrs — mos — ds.

18 Where did disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schumacher, M. D.

Nov. 6, 1929 (Address) 1337 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov. 9 1929
20 UNDERTAKER Henry Hoeck Sons, Inc.	ADDRESS 130 E Eager St

Spec.—1-12-23—M&T—500 Blks.

E 50759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-E 50759

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Infirmary (WARD) 6 4

2-FULL NAME Mrs. Edith M. Price

(a) RESIDENCE NO. Church Home & Infirmary WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Dr Charles H Brace

6 DATE OF BIRTH (month, day, and year): May 6, 1859

7 AGE — Years: 70 — Months: 6 — Days: — If LESS than 1 day, hrs. or ..... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Barney Dilley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: R. G. Wood

(Address): 381 West Garrison Ave

15 Filed 7-1929 19 C. HAMPSON JONES, M. D. Registrar

PER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6, 19 29

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1929, to Nov 6, 1929,

that I last saw h[illegible] alive on Nov. 6, 1929,

and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) — yrs. 1 mos 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Gangrene (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) James C. Owings, M. D.

Nov 6, 1929 (Address) Church Home Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md

DATE OF BURIAL: 11/8 1929

20 UNDERTAKER: W M Cook

ADDRESS: 1217 Eutaw St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50760

CERTIFICATE OF DEATH.

74-001 E 50760

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument ST. 12-14 WARD)

2-FULL NAME Alice Hammond

(a) RESIDENCE NO. 104 E 20th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Calvin Hammond

6 DATE OF BIRTH (month, day, and year) Dec 30. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Arendorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Walter Hammond

(Address) 703 N Eutaw St

15 Filed NOV 7 - 1929 C. H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Nov. 6, 1929, that I last saw her alive on Nov 6, 1929, and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
c hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unk

Did an operation precede death? No Date of

Was there an autopsy? autopsy

What test confirmed diagnosis? clinical hist. & findings

(Signed) J. J. Conn M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 11/9 1929

UNDERTAKER H. H. Cook — ADDRESS 1217 E Fayette

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50761

E 50761

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of Baltimore: (No. 914 N. Carey St. 16-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E. Woodson

(a) RESIDENCE NO. 825 N. Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm E.

6 DATE OF BIRTH (month, day and year) May 27-1840

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	89	5	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Sidney Speeden

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Speeden

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Harry E. Woodson
(Address) 825 N. Monroe

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 6 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home 825 Monroe

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. H. Falk, M. D.

(Address) Nov 6 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Nov 8 1929
20 UNDERTAKER	ADDRESS
Millard Cook	621 S. Broad

Important: See instructions on back of certificate.

DEC 1 - 1929 HAMILTON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50762 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50762

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andy Novak

(a) RESIDENCE NO. 1718 Lancaster ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records of

(Address) Baltimore City Hospitals

Filed ..... 19 .... Per C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1925, to Nov. 5, 1929, that I last saw him alive on Nov. 5, 1929 and that death occurred, on the date stated above, at 11:55 ? m.

The CAUSE OF DEATH* was as follows:

Hypocerebrotes, chronic Acute

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C.E.

(Signed) Warren M McLean M. D.

11-6, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	Nov. 7 1929
20 UNDERTAKER	ADDRESS
Joseph J Fahey Sons	1318 Fulton Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 50763

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 S. Fulton Ave. ST. 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Heinzenberger

(a) RESIDENCE NO. 334 S. Fulton Ave. ST., WARD

(Usual place of abode) 57

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Ludwig Heinzenberger

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1851

7 AGE Years	Months	Days 15	If LESS than 1 day, hrs. or min.
77	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Oswald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Lehr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis C. Heinzenberger

(Address) 334 S. Fulton Ave.

15 Filed 1928 C. HAMILTON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 5 1929

that I last saw h alive on Nov 5 1929

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

*Chronic Interstitial Nephritis

uncertain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11/5/29 (Address) 343 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 8 1929
20 UNDERTAKER Harry N. Nuttle	ADDRESS 530 [illegible]

Cor.—12-9-25—A Co.—200 Bks.

E 50764 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50763

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 302 N Ann St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary B. Thomas

(a) RESIDENCE NO. 302 N Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Howard Thomas

6 DATE OF BIRTH (month, day, and year): May 5th 1908

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21	5	09	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town): N. C.

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: Howard Thomas

(Address): 302 Ann st.

Filed NOV 7 - 1929 HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 3/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial & Nephritis Disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Roan M. D.

(Coroner)

(Address) 11/7/29 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial Nov 7, 1929

UNDERTAKER: Mrs. R. G. Elliott ADDRESS 1225 Ash

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50765

CERTIFICATE OF DEATH

X 191 E 50765

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 9-17 Ward)

2-FULL NAME Joseph Marion Almony

(a) RESIDENCE NO. Street, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Almony

6 DATE OF BIRTH (month, day, and year) Feb 26/1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	43	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Md.

PARENTS

10 NAME OF FATHER Joseph Almony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co., Md.

12 MAIDEN NAME OF MOTHER Mary Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co., Md.

14 Informant E. G. Kurtz & Son
(Address) Jarrettsville, Md.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

- 1929 -

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage-Fracture of Skull due to gun shot wound of head. (Homicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? White Hall, Md.

Did an operation precede death? NO Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. H. Coulson M. D.

11/7/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cemetery Harford Co

DATE OF BURIAL Nov 7 1929

20 UNDERTAKER E G Kurtz Son

ADDRESS Jarrettsville Md

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 50766

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1522 Jackson St. ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Russ

(a) RESIDENCE NO. 1522 Jackson St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred (yrs. 3) mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Russ

6 DATE OF BIRTH (month, day, and year) Unk. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
38	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER August Czarnik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Katie Sokulska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Russ

(Address) 1522 Jackson St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6. 29

17 I HEREBY CERTIFY, That I attended deceased from April 19 29, to Nov. 6. 19 29

that I last saw h. alive on Nov. 6 19 29

and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Cancer stomach & liver

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. S. Hurtz M. D.

11. 7. 1929 (Address) 516 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	Nov 9 1929
UNDERTAKER F. W. Ozgowski	ADDRESS 1930 Eastern Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50767

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST 14-20 WARD)

2—FULL NAME Mary E. Brown

(a) RESIDENCE NO. 1526 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): West Virginia

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records of

(Address) Balto. City Hospitals

15 Filed 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929, to Nov. 5, 1929, that I last saw her alive on Nov. 5, 1929, and that death occurred, on the date stated above, at 12:35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Parenchymatous

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.E.

(Signed) Harvey W. McLeod, M. D.

11-6, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov. 8. 1929
UNDERTAKER: Eugene Wates	ADDRESS 842 Harlem ave.

Spec.—1-10-21—M&T—1500 Bks.

E 50768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 50763

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 E. Federal ST. 8-16 WARD)

2-FULL NAME Paul G. Dengler

(a) RESIDENCE NO. 2104 E. Federal ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catharine Dengler

6 DATE OF BIRTH (month, day, and year): Oct 17 1892

7 AGE — Years: 37 — Months: — Days: 18 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bldr. work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Adam J. Dengler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Catharine Zeblin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Catharine Dengler (Address): 2104 E Fredrick

15 Filed 7 - 1929 (19) C. HAMPSON JONES, M. D. Registrar

By AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 5 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Nov 5, 1929,

that I last saw him alive on Nov 5, 1929

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis. General Anasarca

& Cardiac Insufficiency

(duration) Phthisis abdomen 8 yrs. 2 9 mos ds.

CONTRIBUTORY (Secondary) Phthisis Pulmonalis & Cardiac Insufficiency (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopical

(Signed) C. C. Carman, M. D.

(Address) 1701 N. Carolina st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Nov 8 1929

20 UNDERTAKER: M. F. & E. Deppe Jr. — ADDRESS: 37 Lamb

Sec. 7. Duplicate to be kept by undertaker. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50769 — 90 — E 50769

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Fleet ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cathrine Olszenska

(a) RESIDENCE NO. 209 S Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if foreign birth? 90 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John

6 DATE OF BIRTH (month, day, and year): Nov 12 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64 66	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): 937

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Pawlen

(Address): 209 S Ann St

15 Filed: - 1929 — C. HAMPSON JONES, M. D. Registrar — By: [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 6-29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1929, to Nov. 4, 1929, that I last saw h.. alive on Nov. 4, 1929 and that death occurred, on ~~the date stated above~~ Nov. 6, 1929 at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerotic Cardio - vascular disease - with Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Accident - Thrombosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Neurologic Signs + Symptoms

(Signed) Hyman S Rubinstein, M. D.

, 19 (Address) 2226 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baby Grove	Nov 9 1929
20 UNDERTAKER	ADDRESS
W. E. Dugdale	37 Hamil

Spec.—2-29-28—L. F. S.—500 Blks.

E 50770 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 50770

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Carroll ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Male Infant of LeRoy & Rose Rolen

(a) RESIDENCE NO. 1103 Carroll ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. —mos. —ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Wh. | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11-6-1929

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER LeRoy Rolen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rose Ruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

Informant LeRoy Rolen

(Address) 1103 Carroll St

Filed 8-1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov 6, 1929.

that I last saw h— alive on Nov 6, 1929

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw Newburn M. D.

, 19 (Address) 24 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. | DATE OF BURIAL: 11-7 1929

20 UNDERTAKER: Bernard C Hahn | ADDRESS: 1000 S Paca St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50771 ✓ 100-001 E 50771

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2050 Harford Avenue ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lilly Guertler

(a) RESIDENCE NO. 2050 Harford Avenue. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Charles Guertler

6 DATE OF BIRTH (month, day, and year) 10,22,1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER J. Buschman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Charles Guertler

(Address) 2050 Harford Avenue

15 Filed 8-1929 19 J. LAMBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1929, to Nov 6th, 1929, that I last saw her alive on Nov 5, 1929 and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) A. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr M. D.

, 19 (Address) 300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	10/8 1929

20 UNDERTAKER George & Ruth ADDRESS 1735 Harford Av

Spec.—1-10-21—M&T—1500 Bks.

E 50772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

REGISTERED NO. E 50772

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 Lanvale ST. 17-24 WARD)

2-FULL NAME Annie F. Brown

(a) RESIDENCE NO. 631 Lanvale ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Brown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper 1870

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Mrs. J. Taylor-

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER Johnson Tuppa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Herman Brown
(Address) 631 Lanvale St

15 Filed 8-1929 E. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/VI 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 1924 to Nov VI 1929.

that I last saw h[illegible] alive on 11/VI 1929, and that death occurred, on the date stated above, at 7.45 P. M.

The CAUSE OF DEATH* was as follows: Cancer of the Stomach 5 yrs

(duration) yrs. V mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Thiele M. D.

. 19 (Address) 714 Mad Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 11/9 1929

UNDERTAKER Geo. Ks. H. Holland — ADDRESS 1631 Druid Hill

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50773 ✓ 45 E 50773

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Church Home and Infirmary ST., 69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie Belle Peterson

(a) RESIDENCE NO. Church Home and Infirmary ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1856

7 AGE	Years	Months	Days 21	If LESS than 1 day, hrs. or min.
	73	8	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Charles A. Peterson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sweden

12 MAIDEN NAME OF MOTHER Susan K. Hilton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

Informant Mrs. Estelle G. Wallace
(Address) 3301 Elgin Avenue

Filed 8 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1926, to Nov. 6, 1929,
that I last saw her alive on November 6, 1929
and that death occurred, on the date stated above, at 12 Midnight.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Arterial Sclerosis of
Coronary Vessels
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Carcinoma of Colon
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Vernon N Rowland, M. D.

11/7, 1929 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov. 9 1929
20 UNDERTAKER Ralph J Cook	ADDRESS 1003 W. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50774 — 74-001 — E 50774

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1613 Bolton St. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Nelson

(a) RESIDENCE NO. 1613 Bolton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 21,1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER John W. Street

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Bartell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

Informant Helen Wallace

(Address) 1613 Bolton St

FILED V 8 - 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6,1929

17 I HEREBY CERTIFY, That I attended deceased from June 25th, 19 28, to November 5, 19 29, that I last saw her alive on November 5, 19 29 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 1 Yr.
Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Kenealen M. D.

11/6 19 29 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Saint Mary (Dayton) Md	Nov 8 1929
20 UNDERTAKER	ADDRESS
James [illegible] & Co	324 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

E 50775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 161-001 E 50775

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3245 E Balto St. ST. 76-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olga Marie Segelken

(a) RESIDENCE NO. 3245 E. Balto ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1929

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry K. Segelken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes E. Moreland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14

Informant Henry K. Segelken

(Address) 3245 E. Balto St

15

Filed NOV 8 - 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1929, to Nov. 7, 1929, that I last saw living on Nov. 7, 1929, and that death occurred, on the date stated above, at 7 30 m

The CAUSE OF DEATH* was as follows:

Traumatism

Premature Birth 7 mos

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical signs

(Signed) Chas Disney, M. D.

11/8/29 (Address) 408 Cat Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: Nov. 8 1929

20 UNDERTAKER: H. Sander Sons Inc — ADDRESS: 1710 Eutaw

C. HAMILTON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

E 50776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50776

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 10-13 Ward)

2-FULL NAME Lucy E. Sturdivant

(a) RESIDENCE NO. 1407 Barnes St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Willie M. Sturdivant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S.C.

PARENTS

10 NAME OF FATHER James Bridlef

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S.C.

12 MAIDEN NAME OF MOTHER Lucy E. Bridlef

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S.C.

14 Informant James V. Sturdivant
(Address) 1407 Barnes St

15 Filed NOV 8 - 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Cullen, M. D.

1/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodstock N C — DATE OF BURIAL Nov 7 1929

20 UNDERTAKER Chas Bryan — ADDRESS 1631 Orleans St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50777

CERTIFICATE OF DEATH

99-002
E 50777

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 713 Homestead ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie M. Walsh

(a) RESIDENCE NO. 713 Homestead ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Timothy Walsh.

6 DATE OF BIRTH (month, day, and year) Dec 31st 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83.	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER James O'Reilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Reilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Joseph J. Kane.
(Address) 713 Homestead St

15 Filed 8-1929, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to Nov. 6, 1929, that I last saw h[er] alive on Nov. 6, 1929, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chr Bronchitis 4 Months
Arterio-sclerosis 5 Years
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. 30 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course & Blood Exam

(Signed) apparatus J M Dellett, M. D.

(Address) Nov. 8, 1929 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Nov. 9th 1929
20 UNDERTAKER	ADDRESS
Tilus & Cowan & Son	701 Lafayette Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50778

CERTIFICATE OF DEATH.

31 E 50778

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2368 Mount ST. 1928 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Hagan

(a) RESIDENCE NO. 2368 Mount ST., 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) September

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tool Maker

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Hagan

(Address) 2212 Hamburg St

15 Filed 8-1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Nov 5, 1929, that I last saw him alive on Nov 3, 1929, and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) Nr yrs. 3 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) R. V. Gilmour, M. D.

(Address) 27 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Nov 8th 1929

20 UNDERTAKER A. Jones

ADDRESS W. L. Gilmour

Spec.—1-10-21—M&T—1500 Bks.

E 50779

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50779

CERTIFICATE OF DEATH.

161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 E. 21st Stret ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russel H. Forsyth

(a) RESIDENCE NO. 731 E. 21st Stret ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~M~~ Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 27, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Russel H Forsyth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen J. Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Russel H. Forsyth

(Address) 731 E. 21st Street

NOV 8 - 1929

Filed

C. H[illegible]SON JONES, M.D.

Per

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Nov. 8, 1929, that I last saw him alive on Oct 24, 1929 and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

7 Mo. Premature Child

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(duration) yrs. mos. 1/2 hr

18 Where was disease contracted if not at place of death? 731 E 21st St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs of Acute Dilation

(Signed) Walter C Bacon, M. D.

Nov 8, 1929 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dund Ridge Cemetery	Nov 1929
UNDERTAKER C. LeRoy Stiffler, Inc	ADDRESS 125 E Northern

Spec.—2-29-28—L. F. S.—500 Blks.

E 50780 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 50780

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 31

CITY OF BALTIMORE: (No. 16-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adolph Kramer

(a) RESIDENCE NO. Baltimore City Hospitals ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. 11 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Ethman Kramer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lottie Hardnt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Hospital Records

(Address)

Filed ....., 19 ..... Registrar

3044

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1925, to Nov. 4, 1929,

that I last saw him alive on Nov. 4, 1929

and that death occurred, on the date stated above, at 11.35 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

11-5, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19 NOV 7 - 1929

20 UNDERTAKER HAMPSON JONES, M. D.

Address [illegible] Health.

Spec.—1-10-21—M&T—1500 Blks.

E 50781. HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50781

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daley Jirl Williams

(a) RESIDENCE NO. 139 W. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	B	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28, 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Williams.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina.

12 MAIDEN NAME OF MOTHER Marie Dortch.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14

Informant Marie Williams.

(Address) 139 W. Preston St.

15

Filed [illegible] HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1929.

17

I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Oct 30, 1929,

that I last saw her alive on Oct 30, 1929,

and that death occurred, on the date stated above, at 4 0 m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Blood Pressure. unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Frank A Kelly M. D.

(Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

NOV 7 - 1929

Spec.—2-20-28—I. F. S.—500 Blks.

E 50782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 50782

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2714 Hugo Ave., ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME HARRY C. HEINEMAN

(a) RESIDENCE NO. 2714 Hugo Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) July 26, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 30 years

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER John Heineman

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria T. Yingling

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

Informant John Heineman (Father)

(Address) 2714 Hugo Ave.

Filed ....., 19.... C. HAMPSON JONES, M. D.
8-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1927, to Nov 6, 1929, that I last saw h.. alive on Nov 5, 1929, and that death occurred, on the date stated above, at 9.00 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Pharynx

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Lungs

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman M. D.

11/7. 1929 (Address) 2858 Maryland Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Nov. 8 1929
20 UNDERTAKER	ADDRESS
Henry Sander & Sons, Inc.	Baltimore & Broadway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50783

CERTIFICATE OF DEATH.

101-40 E 50783

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph Hospital 26-40 WARD)

2-FULL NAME Elizabeth J. Hofstetter

(a) RESIDENCE NO. 321 N Eutaw Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(h) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frederick A. Hofstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Teresa Stallman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mr. Frederick A. Hofstetter

(Address) 321 Eutaw Ave

15 Filed NOV 8 - 1929, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/8/29 19

17

I HEREBY CERTIFY, That I attended deceased from 11/3/29, 19 .. to 11/8/29, 19 .., that I last saw h alive on 11/8/29, 19 .., and that death occurred, on the date stated above, at 12:25 p.m.

The CAUSE OF DEATH* was as follows:

empyema thoracis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) lobar pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11/3/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M H Lindner, M. D.

(Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Nov. 11 1929

20 UNDERTAKER Henry Hoen's Sons, Inc. — ADDRESS 130 E Eager St

Cor.—10-10-29—A Co.—100 Blks.

E 50784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50784

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1231 S. Clinton St., 46-1 Ward)

2-FULL NAME Charles Jacobs.

(a) RESIDENCE NO. 1231 S Clinton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Jacob

6 DATE OF BIRTH (month, day, and year): May 18 1862

7 AGE: Years 67 Months 5 Days 18 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Glue
(b) General nature of industry, business, or establishment in which employed (or employer): Bagby Furniture Co
(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER: John Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm J Treuberry (Address) 1231 S. Clinton

15 Filed ..... 19 ..... Registrar

NOV 8 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Chronic (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Autopsy

(Signed) C. G. Glades, M. D.

19 (Address) 270 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Nov 9 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 St Paul

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50785

CERTIFICATE OF DEATH

188-103 E 50785

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp St. 27-49 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Louise May

(a) RESIDENCE NO. 4670 York Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (Write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas L. May

6 DATE OF BIRTH (month, day, and year) Sept 16-1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	77	1	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Work
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Peter Mahn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Rouch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Margaret Berger
(Address) 709 Park Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract R. Hip
Struck by auto while awaiting to board car
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Coronary Embolism
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? York Rd & Willow

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. Hamer M. D.

11-7 1929 (Address) 2931 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Nov 9th 1929
20 UNDERTAKER	ADDRESS
Wm Cook 1217	St Paul St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Schmuck 4012 Park Heights Ave

E 50786 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50786

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5-58 Pall Mall Rd & Park Heights Terrace ST., WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry R Davis

(a) RESIDENCE NO. Pall Mall Rd & Park Heights Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella E Davis

6 DATE OF BIRTH (month, day, and year) Dec 17 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alexander Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Redden

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lasse Davis

(Address) St Petersburg Fla

15 Filed NOV 9 1929 G. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5. 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 4 1929 to Nov 5 1929

that I last saw him alive on Nov 5 1929

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Jno. S. Schmuck, M. D.

Nov 8. 29 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL David Rudge

DATE OF BURIAL Nov 9 1929

20 UNDERTAKER P. M. Cook

ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 50787

Dr Eisenberg 2025 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 50787.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 N. Washington ST. 8-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Rosazza Jr

(a) RESIDENCE NO. 1829 N. Washington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER John E Rosazza

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Montverde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph Rosazza
(Address) 1829 N Washington St

15 Filed NOV 8 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from October 10, 1929, to November 7, 1929, that I last saw h[illegible] alive on November 6 1929, and that death occurred, on the date stated above, at 6.00 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Metastasis and Cachexia (duration) yrs. mos. 29 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Eisenberg, M. D.

11/7, 1929 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery — DATE OF BURIAL Nov 11th 1929

UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Arlin 2827 Calvert St Upton 0324

E 50788 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Sat 9 a.m. 11-24

1—PLACE OF DEATH

REGISTERED NO. E 50788

CITY OF BALTIMORE (No. 1924 Light ST. 23-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Davison

(a) RESIDENCE NO. 1924 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Davison

6 DATE OF BIRTH (month, day, and year) Nov 8 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

10 NAME OF FATHER Henry Friday

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Louisa Kent

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

Informant James Davison

(Address) 1924 Light St

NOV 8 - 1929

WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1929

17

I HEREBY CERTIFY, That I attended deceased from August 27, 1929, to Nov. 6, 1929, that I last saw h[illegible] alive on Nov 5, 1929, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick D. Otten, M. D.

, 19 (Address) 2827 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 11/9 1929

UNDERTAKER D. H. Cook

ADDRESS 1317 E. Pratt St

Spec.—1-10-21—M&T—1500 Bks.

E 50789

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 E 50789

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Division ST.) 14-20 (WARD)

2-FULL NAME Ellen Dooley

(a) RESIDENCE NO. 1724 Division ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. ~~4 COLOR OR RACE~~ Colored 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Dooley

6 DATE OF BIRTH (month, day, and year) 1879-

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ellen Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Thomas Johnson
(Address) 1724 Division St

15 Filed . 19 HARRISON JONES, M. - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 28 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct 28th 29 to Nov 28 1929.

that I last saw h[illegible] alive on Nov. 28 1929.

and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) yrs. mos 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Pneumonia Bl

What test confirmed diagnosis? Physical

(Signed) H. [illegible] M. D.

(Address) 724 Mad Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ware Neck Va — DATE OF BURIAL 11-9 1929

20 UNDERTAKER David Gordon — ADDRESS 916 Pa Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50790

CERTIFICATE OF DEATH

× 100-00

E 50790

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Davis

(a) RESIDENCE NO. 1328 McCulloh ST., WARD Penna.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 25-1929

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5	12	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

10 NAME OF FATHER Henry Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Ruth Jessoms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

Informant Ruth Davis

(Address) 1328 McCulloh St

Filed 11-8 1929 HOMER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7-24

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 19 24, to Nov 7, 19 24, that I last saw h[illegible] alive on Nov 7, 19 24, and that death occurred, on the date stated above, at 7 15-a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

11-8, 19 24 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-9 1929
20 UNDERTAKER Dennis Carter	ADDRESS 916 Pine

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50791

CERTIFICATE OF DEATH

129 E 50791

1-PLACE OF DEATH

City of Baltimore: (No. 1532 Wilmer St. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances A Reynolds

(a) RESIDENCE NO. 1532 Wilmer St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ns.

6 DATE OF BIRTH (month, day and year) July 24-1909

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	20	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer) Ofc
(c) Name of employer

9 BIRTHPLACE (city or town) md
(State or country)

PARENTS

10 NAME OF FATHER John H Reynolds

11 BIRTHPLACE OF FATHER (city or town) Balt Co
(State or country) md

12 MAIDEN NAME OF MOTHER Frances Jones

13 BIRTHPLACE OF MOTHER (city or town) Carlton Co
(State or country) md

14 Informant Minnie Reynolds
(Address) 1532 Wilmer

Filed AUG 8 1929 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Regester Keelwith Coroner, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8-8 1929
20 UNDERTAKER Daniel Easton	ADDRESS 916 Ca ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Kellum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50792

CERTIFICATE OF DEATH

101-001

E 50792

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1319 N. Carey St. 15-22 Ward)

2-FULL NAME Dan F. Kellum

(a) RESIDENCE NO. 1319 N. Carey St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen

6 DATE OF BIRTH (month, day, and year) Nov 24-1878

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	50	11	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Wm H. Kellum

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Rawlings

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Helen Kellum
(Address) 1319 N Carey

15 Filed ....., 19 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Dr. F. C. Leuth M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	11-11 1929
20 UNDERTAKER Harry T. Clause Son	ADDRESS 1400 Mad

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

Sitar

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 50793

CERTIFICATE OF DEATH

E 50793

1-PLACE OF DEATH

City of Baltimore: (No. 3013 E. Fayette St., 26-34 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antoinette L. Sitar

(a) RESIDENCE NO. 3013 E. Fayette St., 26 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3/29

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Stephen P. Sitar

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sparrows Pt. Md.

12 MAIDEN NAME OF MOTHER Grace Nardone

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Stephen P. Sitar (Father)
(Address) 3013 E. Fayette St.

Filed NOV 8 - 1929 HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

11/7/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Nov 9 19 29
20 UNDERTAKER Lilly + Guier Inc	ADDRESS 4030 Woodland Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Bks.

22 9834
E 50794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

14-002E 50794

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 16-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Krueslein

(a) RESIDENCE NO. 234 S. Conkling ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Sebastian Krueslein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 8-1923 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct-6, 19 29, to Nov 6, 19 29, that I last saw h.im alive on 11-6-29, 19, and that death occurred, on the date stated above, at 7 00 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus
Cerebral Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-23-29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) H. H. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Nov 9 1929

20 UNDERTAKER D. Lilly & Sons Inc ADDRESS 4038 Woodland

Spec.—2-29-28—L. F. S.—500 Blks.

E 50795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 50795

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST. 4-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME J. Wesley Buchman

(a) RESIDENCE NO. Hampstead, Md. St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Buchman

6 DATE OF BIRTH (month, day, and year) 12-17-1859

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Hampstead Maryland

10 NAME OF FATHER William Buchman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Zepp.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Wm Buchman

(Address) Hampstead Md

FILED 1929 C. HAMPSON JONES, M. D. Registrar

By NKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1929, to Nov. 8, 1929

that I last saw h[illegible] alive on Nov 8, 1929

and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Appendicitis, acute with abscess.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-8-29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George H. Yeager, M. D.

11-8, 1929 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hampstead Md	11-10 1929
20 UNDERTAKER	ADDRESS
Edw C Tipton	Hampstead Md

Spec.—2-29-28—L. F. S.—500 Blks.

E 50796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50796

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3208 Chesterfield ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna M Siegel

(a) RESIDENCE NO. 3208 Chesterfield ave ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Christian H. Siegel

7 DATE OF BIRTH (month, day, and year): June 24th 1854

8 AGE: Years 75 Months 4 Days 13 If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 639

(c) Name of employer: Self

BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Kinsley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Kinsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Ina Heneka

(Address) 3208 Chesterfield ave

Filed 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 26 1929, to Nov. 6 1929, that I last saw h er alive on Nov. 6 1929 and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Arteria. sclerosis

Myocarditis

Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage (apoplexy)

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigiani M. D.

. 19 (Address) 2942 Wyaget L.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 11/9/1929

UNDERTAKER: Geo. Weber & Son

ADDRESS: 2503 Edmondson ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50797

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-00 E 50797

1—PLACE OF DEATH Dickeson

REGISTERED NO.

CITY OF BALTIMORE: (No. 1725 Park Ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Talbot Dickeson Smith

(a) RESIDENCE NO. 1725 Park Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. life ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Juliette Whitely Smith

6 DATE OF BIRTH (month, day, and year) April 26, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54 yrs	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Shell Oil Co.

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Alan P. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emily Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant B. W. Dickeson

(Address) Charlestown Md.

15 Filed C. HAMPSON JONES, M. D. Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 1929, to Nov 7th 1929,

that I last saw him alive on Nov 7th 1929

and that death occurred, on the date stated above, at 3.P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1725 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	11-9-1929
20 UNDERTAKER Henry W. Jenkins & Sons Co.	ADDRESS Orchard & Calhoun

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50793

CERTIFICATE OF DEATH

1854 E 50793

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital. 9-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick J. Hoffman.

(a) RESIDENCE NO. 249 S. Broadway. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married.

5a If married, ~~widowed or divorced~~ HUSBAND of ~~XXXXXXX~~ Mary Hoffman.

6 DATE OF BIRTH (month, day, and year) August 6, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	8	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman, ✓
(b) General nature of industry, business, or establishment in which employed (or employer) Federal Reserve Bank.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Henry P. Hoffman.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Matilda Hergenrother.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Mary Hoffman. (wife)
(Address) 249 S. Broadway.

15 Filed G. HAMPSON JONES, M. D., Registrar
1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) November 7, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall from platform to drive-way

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Federal Reserve Bank Lexington & Calvert

Did an operation precede death? Yes. Date of 11/7/29

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry

(Signed) Otto M. Eismandt, M. D.

11/8. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lebanon	Nov 10 1929
20 UNDERTAKER M. W. E. Hyde & Bro.	ADDRESS 82 Lanvale

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 50799

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2238 Mura. ST., 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles S. Iconrad.

(a) RESIDENCE NO. 2238 Mura ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 1929

7 AGE: Years | Months: 1 | Days: 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John W. Iconrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Maria Heal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John W. Iconrad
(Address) 2238 Mura St.

15 Filed 11-9-1929 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8-29

17 I HEREBY CERTIFY, That I attended deceased from 10-25-29 to 11-8 1929, that I last saw h alive on 11-7 1929 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows: Pleo Colitis (acute)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred Lee Lee M. D.

(Address) 800 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Nov 9 1929

20 UNDERTAKER: Mrs E. Millerstown — ADDRESS 2334 Jefferson St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50800 — 1929-095 — E 50800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Mem Hospital 28 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Bailey

(a) RESIDENCE NO. 4305 Ethland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sydnor Bailey

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 669

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph Boss

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Katharine Mahane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Katharine Ball

(Address) 5729 Govans Ave

15 1929

C. HAMPSON JONES, M. D.

Registrar

Dat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Acute Dilatation of Heart

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. J. Mooney M. D.

(Coroner)

11/8. 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — Date of Burial 11/9 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 50801 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 137 E 50801

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary ST. 1-26 WARD)

2-FULL NAME Mrs. Ida Charles

(a) RESIDENCE NO. 300) East Baltimore ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of John F. Charles

6 DATE OF BIRTH (month, day, and year) March 30 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Henry Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Phebe Dorney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John F. Charles (Address) 3005 E Baltimore St

15 Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7 1929

17 I HEREBY CERTIFY, That I attended deceased from September 20, 1929, to November 7, 1929, that I last saw her alive on November 7, 1929, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Peri-nephric abscess, left.
Nephrolithiasis, left.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home of disease

Did an operation precede death? Yes Date of November 1, 1929

Was there an autopsy? Partial; rt. kidney removed.

What test confirmed diagnosis? Operation

(Signed) Irvin B. Wallace M. D.

. 19 (Address) Church Home Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 11/12 1929

20 UNDERTAKER W. M. Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

220469
2250802

HEALTH DEPARTMENT—CITY OF BALTIMORE

5 1√ E 50802

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. (or R.F.D.) 10-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Green

(a) RESIDENCE NO. 601 Private Place ST., Pimlico WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-27-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joe Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1929, 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-8 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 24, 1929, to Nov 8, 1929, that I last saw h.er alive on Nov 8, 1929 and that death occurred, on the date stated above, at 5 15 A m.

The CAUSE OF DEATH* was as follows:

Lymmatic Pancarditis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj. E. Hodge, M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Nov 9 1929

20 UNDERTAKER Samuel J. Wemsley ADDRESS 822 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

E 50803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-004 E 50803

1-PLACE OF DEATH

City of Baltimore: (No. 504 Cumnock St., 17th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Johnson

(a) RESIDENCE NO. 504 Cumnock St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 Color or Race Col

5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1928

7 AGE Years 1 Months 4 Days 7 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Sam Johnson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Hopkins

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Nannie Johnson
(Address) 504 Cumnock

15 Filed ....., 19.... 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 8 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) Marilyn C. Klinck M. D.

Nov. 10 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL Nov 9 29

20 UNDERTAKER Samuel Stansbury ADDRESS 5[illegible]

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50804

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50804

CERTIFICATE OF DEATH.

100-20

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Park ave St. 11-24 WARD)

2-FULL NAME Ethelene Felton

(a) RESIDENCE NO. 1026 Park ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3. 1918

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
11	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harmon Felton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillie Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harmon Felton
(Address) 1026 Park Ave

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D.
Registrar

9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Mar. 3, 1929, that I last saw h alive on Mar 6, 1929, and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs — mos 6 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Felton, M. D.

, 19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	11/9/29

20 UNDERTAKER Samuel J. Beverley

ADDRESS 515 N. Bradford

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50805

CERTIFICATE OF DEATH

94 1001 E 50805

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2815 Wallbrook Ave. 15-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Talbot Sharp

(a) RESIDENCE NO. 2815 Wallbrook Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude S. Sharp

6 DATE OF BIRTH (month, day, and year): Mar. 31, 1842

7 AGE: Years 87 | Months 7 | Days 7 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Norfolk Va.

10 NAME OF FATHER: Wm W. Sharp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norfolk Va.

12 MAIDEN NAME OF MOTHER: Mary Ann L. Schofield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Portsmouth Va.

Informant: Miss Evelyn W. Sharp

(Address) 2815 Wallbrook Ave

FILED 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19th, 1929, to Nov. 6th, 1929, that I last saw h[illegible] alive on Nov. 6th, 1929 and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Accidental fall on the floor on Oct. 19th 29.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Apoplexy

(duration) yrs. mos. 1 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac L. Dickson, M. D.

(Address) 3053 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Nov 9 1929

20 UNDERTAKER: Wm Tuckner Sons ADDRESS North Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 50806

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50806

100-09

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. B-57

CITY OF BALTIMORE: (No. 3630 Buena Vista St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ester Ruth Nash.

(a) RESIDENCE NO. 3630 Buena Vista St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23/27

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11 10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. at

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER Charles L. Nash.

11 BIRTHPLACE OF FATHER (city or town) md.
(State or country)

12 MAIDEN NAME OF MOTHER Dora Shuler.

13 BIRTHPLACE OF MOTHER (city or town) md.
(State or country)

14 Informant Charles L. Nash.

(Address) 3630 Buena Vista

15 Filed 9-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8/29.

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Nov 8, 1929, that I last saw h[illegible] alive on Nov 8 d, 1929 and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) any yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Pneumonic Symptoms

(Signed) Thos H. Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Balto Co	Nov 10, 1929
20 UNDERTAKER	ADDRESS
Chronowith Son	360 Chester Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 50807

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 16-37 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ennell

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode)

Length of residence In city or town where death occurred 17 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Louis Weldon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Priscilla

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record
(Address)

15 Filed 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/29

17 I HEREBY CERTIFY, That I attended deceased from 10/26, 1929, to 11/7, 1929

that I last saw h[illegible] alive on 11/7, 1929

and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma abdominal cavity - origin unknown

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

11/7, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Nov 11 1929
20 UNDERTAKER Thomas E Kelson	ADDRESS 1307 Preston St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50808

CERTIFICATE OF DEATH

X 101-001 E 50808

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 624 Gold ST. 15-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME London Bean

(a) RESIDENCE NO. 624 Gold ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 6, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Va

PARENTS

10 NAME OF FATHER London Bean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bettie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie Turner

(Address) 624 Gold St

15 NOV - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 7, 1929

that I last saw h[illegible] alive on Nov 7, 1929

and that death occurred, on the date stated above, at 1:20 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) V

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? V Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. H. Hatcher M. D.

11/8, 1929 (Address) 1111 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Nov 10 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1203 Preston St

Spec.—2-29-28—L. F. S.—500 Blks.

E 50809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-00 E 50809

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 125-7 Rush. Blvd ST. 9-1-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie Schaudel

(a) RESIDENCE NO. 125-7 Rush Blvd ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry

6 DATE OF BIRTH (month, day, and year) Dec 4 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Henry Foltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Bumgardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Schaudel

(Address) 125-7 Rush. Blvd

15 Filed 9-1-1929, 19 Per HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1929, to Nov. 7, 1929, that I last saw her alive on Nov. 6, 1929 and that death occurred, on the date stated above, at 10 45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 16 ds.

CONTRIBUTOR (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John A. Sherwood M. D.

11/15/29, 19 (Address) 642 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Nor.	11/17, 1929

20 UNDERTAKER Wm Cole 127 St. Paul ADDRESS

Spec.—8-16-29—L. F. S.—100 Blks.

E 50810

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50810

1—PLACE OF DEATH

REGISTERED NO. 1947

CITY OF BALTIMORE: (No. 1439 N Patterson Park Ave (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Gartner

(a) RESIDENCE NO. 1439 N Patterson Park Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Karl Gartner

6 DATE OF BIRTH (month, day, and year) Aug 21-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Nicholas Bauman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Uffelmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Bertha Berkley

(Address) 319 S. St St Wash. Co

15 Filed - 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6-1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1929, to Nov 6, 1929, that I last saw h alive on Nov 6 1929 and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Breast

CONTRIBUTORY (Secondary) Metastasis to Lungs Pleura (duration) 1 yrs. mos.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 16-1924

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Cook, M. D.

11/7 1929 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Nov 9. 1929

20 UNDERTAKER John Ellerton — ADDRESS 2008 Orleans

Cor.—10-10-29—A Co.—100 Bks.

E 50811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

86-001 E 50811

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 18-16 Ward)

2-FULL NAME George Leyton

(a) RESIDENCE NO. 1022 Vine St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) May 12 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Steve Leyton

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Hattie Lellen

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Hattie Leyton
(Address) 1022 Vine St

15 Filed ....., 19.... G. HAMPSON JONES, M. D.
1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Otis Media.

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopic

(Signed) Thos Hatchett, M. D.

Nov. 10 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	11/9/1929
20 UNDERTAKER Mrs. Geo. H. Holland	ADDRESS 631 Edmondson Ave

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 50812

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50812

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 15-58 St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Henrietta Lutzky

(a) RESIDENCE NO. 3422 Park Heights ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Lutzky

6 DATE OF BIRTH (month, day, and year): Dec. 25, 1865

7 AGE: Years 63; Months 11; Days 13; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Adolph Blondheim

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: ~~Henrietta Blondheim~~ Sarah Weinberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mr Bernard Lutzky

15 Filed: -1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929, to Nov 8, 1929, that I last saw ~~h~~ alive on ~~Oct~~ Nov 7, 1929, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

1a Abdominal Carcinomatosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Oct 30-29

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. L. Bauer M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Beth Shalom Cem DATE OF BURIAL 11/10 1929

20 UNDERTAKER: Aaird Sondheim ADDRESS 1110-20 W Lanvale St

Spec.—2-29-28—L. F. S.—500 Bks.

Aimutis

E 50813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 / E 50813

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1021 W. Fayette ST. 18-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Aimutis

(a) RESIDENCE NO. 1021 W. Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ How long in U. S., if foreign birth? ~~yrs.~~ ~~mos.~~ ~~ds.~~
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Dec. 7, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Constantine Aimutis

11 BIRTHPLACE OF FATHER (city or town) Lithuania
(State or country)

12 MAIDEN NAME OF MOTHER Mary Matalis

13 BIRTHPLACE OF MOTHER (city or town) Lithuania
(State or country)

14

Informant Constantine Aimutis

(Address) 1021 W. Fayette St.

15

Filed 9 DEC 1929, 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from October 21, 1929, to November 7, 1929.

that I last saw her alive on November 6, 1929

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

about 6 months (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) J. Leary Cronin M. D.

11-7, 1929 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	11/11 19 29
20 UNDERTAKER	ADDRESS
Chas. B. Kuchaus Sons	637 S. Paca

Spec.—2-29-28—L. F. S.—500 Bks.

E 50814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 50814

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 E Fort Ave ST. 24-32 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James E Coughlin

(a) RESIDENCE NO. 1502 E Fort Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	34	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Shipwork 004

(c) Name of employer Black Diamond Steamship Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Thomas Coughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ella Madden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

PARENTS

14 Informant Mr Thomas Coughlin

(Address) 1502 E Fort Ave

15 FEB 9 - 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7. 1929

17

I HEREBY CERTIFY, That I attended deceased from October 20, 1929 to November 7, 1929

that I last saw him alive on November 6, 1929

and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Acute Dilitation of the Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Edward Harris, M. D.

11.8.29 Address 107 East west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Nov. 11, 1929
20. UNDERTAKER Chas L. Sturm	ADDRESS 1501 E Fort Ave

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 50815

CERTIFICATE OF DEATH.

129 ✓ E 50815

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave St. 20 69 Ward)

2-FULL NAME Mrs Alice McKewin

(a) RESIDENCE NO. Home for the aged of the U.S. Civ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Lifetime mos. _____ ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14, 1853

7 AGE — Years: 76 — Months: 9 — Days: 24 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Vincent Brown

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Carroll County Md.

12 MAIDEN NAME OF MOTHER Ada Carter

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Carroll County Md

14 Informant Etta Cuddy

(Address) 400 N. Fulton Ave.

Filed Nov 9 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 14 1929, to Nov. 8 1929, that I last saw h__ alive on Nov. 6 1929, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 6 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Methods

(Signed) Geo. C. Shannon, M. D.

11/8, 1929 (Address) 700 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Woodlawn Cemetery Nov 9 1929

20 UNDERTAKER — ADDRESS

George J. Smith 1532 Walbrook

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50816 90 E 50816

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1303 Webb ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Malinda Taylor

(a) RESIDENCE NO. 1303 Webb ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Adam Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant Elizabeth Nolan

(Address) 1303 Webb St

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

9 - 1929 Per ADR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Nov 7, 1929.

that I last saw h[illegible] alive on Nov 6 1929

and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

Duration yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

11-7, 1929 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Nov 9, 1929
20 UNDERTAKER Wm. B. G. Elliott	ADDRESS 1725 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 50817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50817

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 E. Gittings ST. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amy Florence Gatton

(a) RESIDENCE NO. 132 E. Gittings ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno Walter Gatton

6 DATE OF BIRTH (month, day, and year): Mar. 19/1892

7 AGE: Years 37 | Months 7 | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: Issac Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Minnie Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Jno Walter Gatton
(Address) 132 E. Gittings St.

15 Filed 9-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8/29

17 I HEREBY CERTIFY, That I attended deceased from Jan — 1929 to Nov. 8 1929.

that I last saw her alive on Nov. 8 1929

and that death occurred, on the date stated above, at 1 25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and Chronic Myocarditis.

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duratinn) yrs. mos. ds.

18 Where was disease cnntracted if not at place of death? —

Did an operation precede death? No Date nf —

Was there an autopsy? No

What test cnnfirmed diagnosis? Clinical

(Signed) C Hann, M. D.

19 (Address) 12.15 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: Nov 11 1929

20 UNDERTAKER: Philip Sterry

ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50813

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50813

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 N Chapel ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antonia Melichar

(a) RESIDENCE NO. 1004 N Chapel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of John

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Beran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Antonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Antonia

(Address) 1004 N Chapel St

15 Filed 9 1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929 to March 29, 1929

that I last saw h[illegible] alive on March 29, 1929

and that death occurred on the date stated above, at [illegible] p. m.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia

Contributory Arteriosclerosis

CONTRIBUTORY (Secondary) (duration) yrs. 2 mos. 1 ds.

Acute Red Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

March 29, 1929 (Address) 606 N Bethel St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 31 1929
20 UNDERTAKER	ADDRESS
[illegible]	[illegible] Maryland

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50819

CERTIFICATE OF DEATH

3 / E 50819

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1625 Pierce St. 14-27 Ward)

2-FULL NAME Jas. Liston

(a) RESIDENCE NO. 1625 Pierce St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Liston

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	25	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N C.

PARENTS

10 NAME OF FATHER John Mc. Liston

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N C

12 MAIDEN NAME OF MOTHER Dora Liston

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N C.

14 Informant Lillie Liston
(Address)

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Hemorrhage of Lungs

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D.

Nov. 6 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	Nov 10 1929
20 UNDERTAKER	ADDRESS
Joseph A. Ivey	709 N. Mountst

Important. See instructions on back of certificate.

Spec. 2-19-29—L. P. S.—500 Blks.

E 50820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-092 E 50820

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon Frey

(a) RESIDENCE NO. Preston + Valley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER John Frey

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Bonnie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston + Valley St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1924 to Nov 7 1929, that I last saw h[illegible] alive on Nov 6 1929 and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senility
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema Lung
(duration) yrs. mos. 3 ds.

18 Where was disease cantracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Clement Woods, M. D.

11/9/29 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	Nov 9 1929

20 UNDERTAKER Rita Niedefeld ADDRESS 914 Gramont Ave

Spec.--2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50821

CERTIFICATE OF DEATH

93 ✓ E 50821

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3608 Woodbine ~~28-6~~ (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Ruhland

(a) RESIDENCE NO. 3608 Woodine Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Ruhland.

6 DATE OF BIRTH (month, day, and year) 10-28-860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Metley?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Metley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Michael J. Roe

(Address) 3605 Wabash ave

15 Filed 11 - 9 - 1929 C. H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-8-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1929, to Nov 8, 1929, that I last saw h... alive on Nov 8, 1929, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Embolism in left Lung

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion of Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) J. C. Reynolds, M. D.

(Address) 1329 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	11-11-29
20 UNDERTAKER Mahool Turkey & Sons	ADDRESS 1521 Harford ave.

Spec.—2-29-28—L. F. S.—500 Bks.

230891

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50822

CERTIFICATE OF DEATH

X 70 E 50822

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSP. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Leffler

(a) RESIDENCE NO. Sanford Florida ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11-25-24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4 yr. 11	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fla

PARENTS

10 NAME OF FATHER Wm A

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fla

12 MAIDEN NAME OF MOTHER Rene Murrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1 0 1929, 19 — C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-9-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov 9, 1929, that I last saw him alive on Nov 9, 1929 and that death occurred, on the date stated above, at 4 55A m.

The CAUSE OF DEATH* was as follows:

Brain abscess

(duration) yrs. 1½ mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 6. XI. 29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) E. H. Compton, M. D.

11/9, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spare.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sanford Fla	Nov 9 1929
20 UNDERTAKER	ADDRESS
John O Mitchell Son	19 W Eutaw

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

230896 L 50823 — CERTIFICATE OF DEATH — + 49 VE 50823 ~~50823~~

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irkins McKinnon Harvey

(a) RESIDENCE NO. Mt Union Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 6-4-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Joseph Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McClellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov 9, 1929, that I last saw h.... alive on Nov 9, 1929 and that death occurred, on the date stated above, at 553 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis uremia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Penna

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Hedwig Koenig, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Union Pa	Nov 12 1929
UNDERTAKER Wallace R Blatt Sr.	ADDRESS Mt Union Pa

NOV 12 1929 by HUMPHREY JONES, M.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50824

CERTIFICATE OF DEATH

90

E 50824

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2109 Baker ST. 15-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Aaron Feit

(a) RESIDENCE NO. 2109 Baker ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Austria
(State or country)

PARENTS

10 NAME OF FATHER Benj H. Feit

11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)

12 MAIDEN NAME OF MOTHER Rosa I. Hurwitz

13 BIRTHPLACE OF MOTHER (city or town) Austria
(State or country)

14 Informant Samuel Feit
(Address) 2608 Park Heights Terrace

15 Filed NOV 10 1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1929, to Nov. 8, 1929; that I last saw him alive on Nov. 8, 1929, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nathan B. Shpritz M. D.

11/9 1929 (Address) 2318 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Nov 10, 29
20 UNDERTAKER Sol Levinson & Bro	ADDRESS 1127 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

E 50825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 50825

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33rd & Calvert ST. 12-40 WARD)

2—FULL NAME Theodore Morgan

(a) RESIDENCE NO. Aberdeen, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	7	22	

8 OCCUPATION OF DECEASED None.

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aberdeen Maryland

PARENTS

10 NAME OF FATHER Thomas E. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Laura Osborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md.

14 Informant Mrs. George Roberts (Sister)

(Address) 3096 E. 31st St. Balto. Md.

15 Filed ..... 19 31 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929, to Nov. 10, 1929

that I last saw h[illegible] alive on Nov. 10, 1929

and that death occurred, on the date stated above, at 2:45 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. about 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) Undetermined ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings.

(Signed) William R. Fargo, M. D.

11/10, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Aberdeen, Md	Nov 13 1929
20 UNDERTAKER [illegible]	ADDRESS [illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50826

CERTIFICATE OF DEATH

74-001

74 E 50826

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Norwood Hgts ST., 18-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A Sauk

(a) RESIDENCE NO. 325 N Carey St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W Sauk

6 DATE OF BIRTH (month, day, and year) Nov 24th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Michael Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Kobylopa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Dennis Sauk

(Address) 2430 Fredrick Ave

15 Filed ..... 19 .....

NOV 10 1929 LAMBERT T. JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 20 1929, to Nov. 8 1929

that I last saw h alive on Nov. 8 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Degeneration

(duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. A. Warren, M. D.

11/9, 19 29 (Address) 1500 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	11/11 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 E Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50827

CERTIFICATE OF DEATH

41 ✓

E 50827

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Brown

(a) RESIDENCE NO. 1711 Friendsbury Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Zacharius Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Annie Duckey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address): Balto. City Hospitals

15 Filed NOV 10 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1926, to Nov. 7, 1929,

that I last saw her alive on Nov. 7, 1929

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic Interstitial

Carcinoma Breast, R. (duration) 2½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Path. Report

(Signed) Marvin M. McLean, M. D.

11-8, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	11/11/29
20 UNDERTAKER	ADDRESS
Wm Cook	127 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50828

CERTIFICATE OF DEATH.

100-001

E 50828

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland 8-16 WARD)

2-FULL NAME Shirley Gerber

(a) RESIDENCE NO. 1322 N. Milton Ave. ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 15-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Benj Gerber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hetta Weiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Benj Gerber (Address) 1322 N. Milton Ave

15 Filed NOV 10 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9-29 19

17 I HEREBY CERTIFY, That I attended deceased from 11-7-29 19 to 11-9-29 19, that I last saw h[illegible] alive on 11-9-29 19, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

1. Pneumonia (Bronch).

2. Pneumonia Meningitis

(duration) yrs. (1) mos. 7 ds.

CONTRIBUTORY (Secondary) (4) 1 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab-

(Signed) A. A. Tolson, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northern Circle Cem — DATE OF BURIAL: 11/10 19 29

20 UNDERTAKER: Jack Lewis — ADDRESS: 1434 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

29865 E 50829

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001 E 50829

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Tapper Call so Joe Tapper

(a) RESIDENCE NO. 212 Asquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Tapper

6 DATE OF BIRTH (month, day, and year): 12-17-83

7 AGE: Years 45 | Months 10 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer): 057

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mary - (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed NOV 10 1928 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov - 8 - 1928

17 I HEREBY CERTIFY That I attended deceased from Nov 4, 1928, to Nov 8, 1928, that I last saw him alive on Nov 8, 1928, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Gastric Ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-7-28

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) C. D. Voss, M. D.

11/9, 1928 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int Earned

DATE OF BURIAL: 11/10, 1928

20 UNDERTAKER: Jack Levin

ADDRESS: 1709 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50830

CERTIFICATE OF DEATH

129 ✓ E 50830

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 336 North Hilton ST. 17-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Rebecca Phillips

(a) RESIDENCE NO. 336 North Hilton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: of the late Charles Peters Phillips

6 DATE OF BIRTH (month, day, and year): Apr 6th 1862

7 AGE: Years 67 | Months 7 | Days 2 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lillian May Baker

(Address) 336 North Hilton

Filed NOV 10 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8th 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to Nov 8, 1929.

that I last saw h.. alive on Nov 7 1929

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis - Arteriosclerosis

Chronic nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. Wilson, M. D.

. 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 11/11/1929

20 UNDERTAKER: Geo. Weber & Son

ADDRESS: 2503 Edmondson

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 50831

REGISTERED NO.

1—PLACE OF DEATH E 50831

CITY OF BALTIMORE: (No. 215 E. Preston ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Clark Wright

(a) RESIDENCE NO. 215 E. Preston ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas T. Wright

6 DATE OF BIRTH (month, day, and year) May 4, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Augusta
(State or country) Ga.

PARENTS

10 NAME OF FATHER Samuel Clark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Adeline E. Moore

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ga.

14 Informant Frances M. Wright

(Address) 215 E. Preston St.

15 C. HARRISON JONES, M. D.

Filed NOV 10 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7th, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 19 29, to Nov 7th, 19 29, that I last saw her alive on Nov. 7th, 19 29, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Stelwin F. Shellman, M. D.

19 (Address) 6 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Nov. 11, 19 29
20 UNDERTAKER John O. Mitchell & Sons	ADDRESS 1900 Eutaw Pl.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50832

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50832

CERTIFICATE OF DEATH

135

1—PLACE OF DEATH Union Memorial Hospital 33rd & Calvert Sts. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas P. Ball

(a) RESIDENCE NO. 3102 Walbrook Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosa W. Stone

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Philip A Ball

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emily H. Latimer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Frances A. Stone
(Address) 1415 Linden Ave.

15 Filed NOV 10 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1929, to Nov 9, 1929, that I last saw him alive on Nov 9, 1929 and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Benign hypertrophy of prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Infarct lung, pneumonia, & septicemia

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Sept 7, Nov 2.

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Francis W. Fleck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Nov. 11. DATE OF BURIAL 1929

20 UNDERTAKER John O. Mitchell & Son ADDRESS Place

Cor.—12-9-25—A Co.—200 Bks.

E 50833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 E 50833

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE, (No. St Joseph Hospital S. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Olson

(a) RESIDENCE NO. 1511 E Lafayette Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 3 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 29 1929

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Carlyle Olson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Dakota

12 MAIDEN NAME OF MOTHER Mary Costello

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Sparta, Greece

14

Informant Mr Carlyle Olson

(Address) 1511 E Lafayette Ave

15 Filed NOV 10 1929 H. Leon Jones M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. Ir. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (Tuberculan?)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. E. Cullen (Coroner) M. D.

11/9/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial Nov 11 1929

20 UNDERTAKER. Wm J Tucker Sons ADDRESS Mt Pleasant

Very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50834 — CERTIFICATE OF DEATH — 90 — E 50834

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Parkhatan St., 5-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Ernestine Small

(a) RESIDENCE NO. 3501 Parkhatan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. — mos. ~~ds.~~ How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank E. Small

6 DATE OF BIRTH (month, day, and year) July 27 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	3	12	11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Albany

(State or country) N. Y.

PARENTS

10 NAME OF FATHER Geo. F. White

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Vermont

12 MAIDEN NAME OF MOTHER Rosanna D. Read

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Vermont

14 Informant L B. Wirtz

(Address) 3501 Parkhatan Ave

15 Filed NOV 10 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8-1929

17 I HEREBY CERTIFY, That I attended deceased from 11/4, 1929, to 11/7, 1929, that I last saw her alive on 11/5, 1929 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Helen Whitehurst M. D.

(Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem	Nov. 11 1929
20 UNDERTAKER W. J. Tuckwell & Son	ADDRESS Northern

Spec.—2-29-28—L. F. S.—500 Bks.

E 50835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 50835

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Rock Glen Rd 28-11 ST. 28 WARD)

2—FULL NAME Ida Virginia Cromier

(a) RESIDENCE NO. 513 Rock Glen Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 0 mos. 5 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas W. Cromer

6 DATE OF BIRTH (month, day, and year): Nov. 3 1853

7 AGE — Years: 76 | Months: 0 | Days: 5 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Geo. M. Hay.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Sabina Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Miss Hermine Cromer

(Address) 513 Rock Glen Rd.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1927, to Nov 8 1929, 19....., that I last saw her alive on Nov 8 1929, 19....., and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Degerative Myocaritis

(duration) 2 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary): Cardica Dilitation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examina

(Signed) [illegible] M. D.

19 (Address) 3400 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: Nov. 11 1929

20 UNDERTAKER: Wm Tuckner Sons ADDRESS North & Pa

Spec.—1-12-23—M&T—500 Blks.

E 50836 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-001

E 50836
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) W. Balto. Jn. Hosp. (Ward) 13-59

2-FULL NAME Laura V. ~~Mrs.~~ ~~Lester~~ Kuster

(a) RESIDENCE No. 2720 Parkwood Ave ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Kuster

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1879

7 AGE Years 50 Months 8 Days 18 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md

10 NAME OF FATHER Joseph Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester Md.

12 MAIDEN NAME OF MOTHER Catherine Boyd.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant John F. Kuster
Address 2720 Parkwood Ave

Filed NOV 16 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7/1929.

17 I HEREBY CERTIFY, That I attended deceased from 10/30, 1929, to 19 ,
that I last saw h[illegible] alive on 11/7, 1929
and that death occurred, on the date stated above, at 9:30 P. M.
The CAUSE OF DEATH* was as follows:
Carcinoma Uteri

(duration) yrs mos 4 ds

CONTRIBUTORY (Secondary) Toxemia (duration) yrs mos 4 ds

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 11/4/29

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Microscopic

(Signed) H. Bologna, M. D.

, 19 (Address) W. Balto. Jn. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL Nov. 12 1929

20 UNDERTAKER Wm. Fickenscher Sons

ADDRESS Hanover Pa

Spec.—8-16-29—L. F. S.—100 Blks.

E 50837 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 50837

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH **REGISTERED NO.**

CITY OF BALTIMORE: (No. 417 Lynhurst Avenue ST. 30-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances A. Murphy

(a) RESIDENCE NO. 417 Lynhurst Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard J. Murphy

6 DATE OF BIRTH (month, day, and year) 2-2- 1877

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
52	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles H. Daiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Debow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Bernard J Murphy

(Address) 417 Lynhurst Avenue

15 Filed 10 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7-29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 26, to 11-7, 1929, that I last saw h[illegible] alive on 11-7, 1929 and that death occurred, on the date stated above, at 7:25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Nephritis

Hypertension

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) 11 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Sh. Wiesel, M. D.

, 19 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	11/ 1929
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford A

Spec.—8-16-29—L. F. S.—100 Blks.

E 50838 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 50838

CERTIFICATE OF DEATH

1—PLACE OF DEATH **423. S. Eden. St.** REGISTERED NO.

CITY OF BALTIMORE: (No. Vincenzo Mercurio ST. 3-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME

(a) RESIDENCE NO. (Usual place of abode) 423 S.Eden St. ST. WARD

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wite	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maddalena Trevisonno

6 DATE OF BIRTH (month, day, and year) Feb.5 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	58	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Taylor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) Larino

(State or country) Italy

PARENTS

10 NAME OF FATHER Raffaele Mercurio

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Vincenza Puchetti

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Giuseppe Merdurio

(Address) 423 S.Eden St.

15 Filed NOV 8 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7. 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1929, to Nov. 7 1929, that I last saw him alive on Nov. 7 1929, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH was as follows:

Paralysis

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirm[illegible]diagnosis?

(Signed) D. J. Cubitta M. D.

, 19 (Address) 811 Scott

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 11 1929

20 UNDERTAKER ADDRESS

George J. Rutt 1736 Hanford

Spec.—2-29-28—L. F. S.—500 Blks.

E 50839 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 128 ✓ E 50839

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 503 S. East Ave. ST. 76-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Merryman

(a) RESIDENCE NO. 503 S. East Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Merryman

6 DATE OF BIRTH (month, day, and year) April 23. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Adam Steinmetz

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant John W. Merryman (Husband)
(Address) 503 S. East Ave.

15 Filed NOV 10 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 3rd, 1929, to Nov 7th, 1929, that I last saw her alive on Nov 7th, 1929 and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Nov. 10, 19 29

20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	Baltimore & Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

E 50840

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50840

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 E. Oliver ST. 8-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca A. Derr

(a) RESIDENCE NO. 1621 E. Oliver ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Vernon E. Derr

6 DATE OF BIRTH (month, day, and year) Jan 21 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	70	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William B. Greenly

11 BIRTHPLACE OF FATHER (city or town) (State or country) born

12 MAIDEN NAME OF MOTHER Emaline Burley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant William Derr

(Address) 1621 E. Oliver st

15 Filed NOV 10 1929, 19 Pfaff. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-7-1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct 8- 1929, to Nov 7- 1929,

that I last saw her alive on Nov 7- 1929

and that death occurred, on the date stated above, at 12-10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? W Date of

Was there an autopsy? W

What test confirmed diagnosis? None

(Signed) E. Gill Hall M. D.

(Address) 1631 E Northan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Nov. 10 1929
20 UNDERTAKER	ADDRESS
William B. Schaffer	1816 Monument

Spec.—1-12-23—M&T—500 Blks.

E 50841

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50841

CERTIFICATE OF DEATH.

51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Millman ST. 4-13 WARD)

2-FULL NAME Mildred Barnes.

(a) RESIDENCE NO. 1617 Millman ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 30. 1912.

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or.... min.
	17	10	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md.

PARENTS

10 NAME OF FATHER Bernard Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) St marys Co. Md.

12 MAIDEN NAME OF MOTHER Amanda Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St marys Co. Md

14 Informant Amanda Barnes

(Address) 1617 Millman st

15 Filed OCT 10 1928 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1927

17

I HEREBY CERTIFY, That I attended deceased from Nov. 1 .1927. to Nov 9 .1927.

that I last saw her alive on Nov. 9 .1927.

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever.

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Bacterial Endocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. B. LeCompte, M. D.

. 19 (Address) 814 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PT Lookout St Marys Co Md

DATE OF BURIAL Nov 11 1927

20 UNDERTAKER Robert F. Williams

ADDRESS 1515 McCulloh St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 50842 ✓ E. 50842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. 50[redacted]

1-PLACE OF DEATH

City of BALTIMORE: (No. 2005 N. Bentalou St. 15-68 90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise C. Shipley

(a) Residence No. 2005 N. Bentalou St., Ward Frederick Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John J. Shipley

6-DATE OF BIRTH (month, day and year) Oct. 14, 1846

7-AGE. 83 yrs. mos. 25 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Ellerton Frederick County Md

PARENTS.

10-NAME OF FATHER. Jerry Gaver

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ellerton Frederick County, Md.

12-MAIDEN NAME OF MOTHER. Rebecca Kline

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ellerton Frederick County Md.

14-

(Informant) Mrs. Eliza Klitz

(Address) 2005 N. Bentalou St.

Filed NOV 10 1929 HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Nov. 9, 1929.

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1928, to Nov. 8, 1929, that I last saw h[illegible] alive on Nov. 8, 1929, and that death occurred, on the date stated above, at 7 45 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) John D. Dunn M. D.

11/9/1929 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Frederick Md

DATE OF BURIAL. Nov. 11, 1929

20-UNDERTAKER. W. M. Master

ADDRESS 22 [illegible] Ave

Spec.—1-10-21—M&T—1500 Bks.

E 50843

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 50843

CERTIFICATE OF DEATH.

E 50843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 1-13 ST., WARD)

2-FULL NAME Mrs. Caroline Nagengast

(a) RESIDENCE NO. Essex, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Wd

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: John Nagengast

6 DATE OF BIRTH (month, day, and year): Jan 11 1866

7 AGE — Years: 63 — Months: 9 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Nagengast

(Address): Stillwater on Essex

15 Filed NOV 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 8, 1929, that I last saw h[er] alive on Nov 7, 1929, and that death occurred, on the date stated above, at 1:17 P.M.

The CAUSE OF DEATH* was as follows:

Ca of head of pancreas

(duration) yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary)

Cardiac Failure (duration) yrs. 1 mos. ? ds.

18 Where was disease contracted if not at place of death? Id.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — DATE OF BURIAL: Nov 11 1929

20 UNDERTAKER: John G. Connelly — ADDRESS: Essex

Spec.—2-29-28—L. F. S.—500 Bks.

E 50844

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50844

CERTIFICATE OF DEATH

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 S. Lakewood Ave ST. WARD 3)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christian Krug.

(a) RESIDENCE NO. 644 S. Lakewood Ave ST. 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 5 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Lillian Krug.

6 DATE OF BIRTH (month, day, and year) May 20th 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Box Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Canton Box Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Friedrich Krug.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Madeline Best

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles A. Carlson Jr.

(Address) 644 S. Lakewood Ave

15 Filed NOV 11 1929 G. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8th 29

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to Nov 8, 1929, that I last saw him alive on Nov 8, 1929, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P. & S.

(Signed) John J. Kruger M. D.

, 19 (Address) 767 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov 11th 1929
20 UNDERTAKER Lilly & Sons	ADDRESS 405 S. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50845

CERTIFICATE OF DEATH

129

E 50845

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Rigg Ave. ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Grandie Wilson

(a) RESIDENCE NO. 1709 Rigg Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Silas Wilson

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Doctor Hancock

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Chetam

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mamie Boyer

(Address) 1629 Winchester St.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 19 29, to Nov 8, 19 29, that I last saw h. alive on Nov 8 19 29 and that death occurred, on the date stated above, at 7:45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F. Wenckebach, M. D.

, 19 (Address) 1504 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Nov. 11 19 29

20 UNDERTAKER Chas. H. Johnson & Co. ADDRESS N. Carolina St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50846

CERTIFICATE OF DEATH

90 E 50846

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 15 S. Payson ST. 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Phillipina Murbach

(a) RESIDENCE NO. 15 S. Payson Street WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob C. Murbach

6 DATE OF BIRTH (month, day, and year) Aug 7th, 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston, Mass.
(State or country)

PARENTS

10 NAME OF FATHER Charles Offney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant August Murbach
(Address) 15 S. Payson Street

15 Filed 1 1 1929 C. HAMPSON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8th, 29.

17 I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 1929, to Nov. 7th, 1929, that I last saw her alive on Nov. 7th, 1929 and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Valvular Heart Disease (Mitral Stenosis)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E Helen Henning, M. D.

11/9, 1929 (Address) 2000 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Nov 11th 29
20 UNDERTAKER	ADDRESS
T. B. Wippert,	1850 W. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50847

CERTIFICATE OF DEATH

100-001

E 50847

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annabelle Nicholas

(a) RESIDENCE NO. 421 East Lyon ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 29 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Mar 10th 1924

7 AGE: Years — Months 7 — Days 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Edna Handy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bells Mill

11 Informant: Chas Nicholas

(Address) 421 East Lyon St

15 Filed NOV 1 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8th 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 1929 to Nov 8 1929

that I last saw her alive on Nov 8 1929

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Meningismus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? —

What test confirmed diagnosis? Physical signs.

(Signed) [illegible] M. D.

Nov 9 1929 (Address) 2526 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov 11th 1929

20 UNDERTAKER: E. D. Wagner — ADDRESS: 1856 W. Bello Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 50848

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50848

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2513 E. Federal ST. 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Galvin. R. Claridge

(a) RESIDENCE NO. 2513 E. Federal ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., If foreign birth? Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Catherine. B. Claridge

6 DATE OF BIRTH (month, day, and year) Aug. 2nd 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Frank Claridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Louisa Hurlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Catherine. B. Claridge

(Address) 2513 E Federal St

15 Filed NOV 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) NOV 9 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-15, 19 29 to 11-9, 29, that I last saw h alive on 11-8-29, and that death occurred, to the date stated above, at 4:20 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) 2 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Y. Siegelman M. D.

11-9, 19 29 (Address) 800 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov. 12 1929
UNDERTAKER	ADDRESS
Henry Hoeck & Sons, Inc.	1301 E Eager St

Spec—1-12-23—MAT—500 Blks.

E 50849 HEALTH DEPARTMENT—CITY OF BALTIMORE 51 E 50849

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 221 N. Bruce St (St.) 19-27 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Etta Briggs

(a) RESIDENCE NO. 221 N. Bruce St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence Briggs

6 DATE OF BIRTH (month, day, and year) June 17, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	31	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harmons, Md.

PARENTS

10 NAME OF FATHER Thomas Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Geo., Md.

12 MAIDEN NAME OF MOTHER Florense Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harmons, Md.

14 Informant Florence Johnson

(Address) 1320 Argyle ave

15 Filed 1-1-1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9- 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26th, 1929, to Nov 9th 1929,

that I last saw her alive on Nov. 8 .29

and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs mos 2 ds.

CONTRIBUTORY (Secondary) Acct. Articular Rheumatism

(duration) yrs mos. 14 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys. Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmons, Md	Nov 11, 1929
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	3221 Schroeder St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50850

CERTIFICATE OF DEATH.

4 E 50850

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument St + Rutland Ave 58 WARD)

2-FULL NAME Mr. Meyer Schnitzer

(a) RESIDENCE No. 1211 Mclldrey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Schnitzer deceased.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Peddler

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Schnitzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Rosen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto St

15 Filed [illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/7, 1929, to 11/10, 1929, that I last saw h/m alive on 11/10, 1929, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

(1) Cerebral Hemorrhage 8 days

(2) Carcinoma of Oesophagus

↓ ?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician's Laboratory

(Signed) A. J. Silver, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest. Rem.

DATE OF BURIAL 11/11 1929

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

PRINT in very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50851

CERTIFICATE OF DEATH

90 ✓ E 50851

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ? ST. 2334 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christina Hengerer

(a) RESIDENCE NO. 1702 Marshall ST., 73 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Hengerer

6 DATE OF BIRTH (month, day, and year): 9/6/53

7 AGE: Years 76 | Months 7 | Days 3 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): ? 031

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Md.

PARENTS

10 NAME OF FATHER: Christian Rose ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Records of [illegible] (Address): BALTIMORE CITY HOSPITALS

15 Filed NOV 1 1929 19 C. HAMBURGER, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-9-29

17 I HEREBY CERTIFY, That I attended deceased from 11-8, 1929, to 11-9, 1929, that I last saw her alive on 11-9, 1929 and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic Parenchymatous

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harris Hirschstein M. D.

11-9, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount DATE OF BURIAL 11/12 1929

20 UNDERTAKER: [illegible] ADDRESS 328 Eutaw Place

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50853

CERTIFICATE OF DEATH

90 E 50853

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE, (No. 1762 E. North ave ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George T. Corprew

(a) RESIDENCE NO. 1762 E. North ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 27-1864

7 AGE	Years	Months	Days 11	If LESS than 1 day, ...hrs. or ....min.
	64	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Corprew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Susanah Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mida C. Corprew

(Address) 1762 E. North ave

15 Filed NOV 11 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8-1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Nov 8, 1929, that I last saw h. alive on Nov 7, 1929 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

Syn Toxic (duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G H Monkaus M. D.

Nov 8, 1929 (Address) 1305 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	11/10 1929
20 UNDERTAKER	ADDRESS
George W. Zirkler	1737 Eager St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50853

CERTIFICATE OF DEATH.

90

E 50853

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2816 Dillon St., 11 Ward)

2-FULL NAME Wladyslaw Kozik

(a) RESIDENCE NO. 2816 Dillon St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Karoline Kozik

6 DATE OF BIRTH (month, day, and year) Oct. 15 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Karoline Kozik

(Address) 2816 Dillon St.

15 Filed 11 29 1929

C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Exhaustion (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

11/29 (Signed) G. Oladdi M. D.

(Coroner)

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem — Date of Burial: Nov. 13 1929

20 UNDERTAKER: Stephan J. Fiałkowski — ADDRESS: 1000 S. Kenwood

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

229087
E 50854

CERTIFICATE OF DEATH

117 E 50854

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST, 913 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Banks

(a) RESIDENCE NO. 903 N. Dallas ST., WARD A-2
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Thomas Banks

6 DATE OF BIRTH (month, day, and year) November 8 90

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) 10 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER William Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Mary Worley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 HAMPTON L. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 8/29

17 I HEREBY CERTIFY, That I attended deceased from September 14, 1929, to November 8, 1929, that I last saw her alive on November 8, 1929 and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of pelvis and abdomen, probably from perforated appendix.

2 weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Overwhelming infection

same (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 10 24 29

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Raymond P. Sayler M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Nov 13, 1929
20 UNDERTAKER Wm. B. Elgin	ADDRESS 1525 Eutaw Pl.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 50355

1—PLACE OF DEATH Balto City Hospts. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto Md 43-31 WARD)

2—FULL NAME Ellen Elkins

(a) RESIDENCE NO. 925 S. Sharp St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
36				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospls

(Address) Balto Md.

15 Filed ..., 19... [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-9-29

17 I HEREBY CERTIFY, That I attended deceased from 11-7-, 1929, to 11-9-, 1929

that I last saw her alive on 11-8-, 1929

and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

11/9, 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Nov 14, 1929
20 UNDERTAKER	ADDRESS
Mrs. B. A. Elliott	1705 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50856 — CERTIFICATE OF DEATH — 31 V — E 50856

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1117 Mc Henry St. (WARD) 8?7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William C Coleman

(a) RESIDENCE NO. 1117 McHenry St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Vashti Coleman

6 DATE OF BIRTH (month, day, and year): Nov. 7 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Ephraim Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Malinda Nuckles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Vashti Coleman
(Address): 1117 McHenry St

15 FILED NOV 11 1929 — C. RAMPSON JONES, M. D. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 1924 to Nov 8 1929 that I last saw h[illegible]live on Nov 7 1929 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Enos Rae, M. D.

11-8 1929 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
McHenry Cemetery	Nov. 11 1929
20 UNDERTAKER: Mrs B. G. Elliott	ADDRESS: 17[illegible] Washington

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Bernd
515 Drury Lane 3 E to Edmondson Ave
Tow Hills

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50857.

CERTIFICATE OF DEATH

14-001

REGISTERED NO. E 50857

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 S. Woodyear ST. 4 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catharine A. Mason

(a) RESIDENCE NO. 337 S Woodyear ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Mason

6 DATE OF BIRTH (month, day, and year) — — 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John R McCulley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Hook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lottie Hunter

(Address) 337 S. Woodyear st

15 Filed ..., 19 ... Registrar

HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1929, to Nov 9, 1929, that I last saw h.. alive on Nov 7, 1929 and that death occurred, on the date stated above, at 9368 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) ... yrs. ... mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Jas. E. Carmody, M. D.

11-10-1929 (Address) 90 N Lemmon st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 12, 1929
20 UNDERTAKER	ADDRESS
Wm Cook 1217	St Paul st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50858

CERTIFICATE OF DEATH

162 V

E 50858

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 729 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Ballman

(a) RESIDENCE NO. Brooklyn, Md. A-A-Co. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 8, 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Allan S Ballman

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Edna Robertson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....
Per ..... Registrar

1 1 1929 H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 8, 1929, to Nov 9, 1929, that I last saw him alive on Nov 9, 1929, and that death occurred, on the date stated above, at 6.40 a.m.

The CAUSE OF DEATH* was as follows:

asphyxia due to atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) maternal eclampsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) E. F. Daily, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hall	11/11 1929
20 UNDERTAKER	ADDRESS
J. M. Cook	1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50859

CERTIFICATE OF DEATH

129 E 50859

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2814 N. Calvert St. (ST.) 12-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel L. Norris

(a) RESIDENCE NO. 2814 N. Calvert St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 18-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boss 086

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer Hutzler Bros. Co.

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER Nicholas Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary McKinstry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. F. J. Abner

(Address) 2814 N. Calvert St.

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9-1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 17 1926 to Nov 9th 1929.

that I last saw him alive on Nov 9th 1929.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
& Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Lungs.

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Horace F. Burgee, M. D.

Nov 11. 1929 (Address) 846 W 36 St. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Co. Linganore Cem. Unionville, Md	Nov. 12 1929

20 UNDERTAKER Horace F. Burgee ADDRESS 3631 Falls Road

Spec.—2-29-28—L. F. S.—500 Blks.

E 50860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 V E 50860

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Annapolis Ave. ST. WARD) 25-37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth G. C. Billings

(a) RESIDENCE NO. 2201 Annapolis Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 8 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Billings

6 DATE OF BIRTH (month, day, and year) Feb. 20, 1906

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha G. Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Bertha Riddling

(Address) 2201 Annapolis Ave

15 Filed [illegible] 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to Nov 8, 1929

that I last saw her alive on Nov 8, 1929

and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Louis T. Levy, M. D.

11/9, 29 (Address) 1740 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov. 11, 1929
20 UNDERTAKER Harry N. Reitzke 1531 N.	ADDRESS Lombard St.

Spec.—8-16-29—L. F. S.—160 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

50861 90 E 50861

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto Md. REGISTERED NO.

CITY OF BALTIMORE: (No. 4704 Roslyn Ave ST. 27-42 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vaclav Roulenc.

(a) RESIDENCE NO. 4704 Roslyn Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Roulenc

6 DATE OF BIRTH (month, day, and year) Apl. 25, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	83	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cesar Stand

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cesr Stand

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cesr Stand

14 Informant Mrs. Rosa Lubin

(Address) 4704 Roslyn Ave

15 Filed 1 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10. 29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1929, to Nov. 10, 1929, that I last saw h[illegible] alive on Nov. 9, 1929, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

probably

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) C. H. Hampson, M. D.

11/10/ 1929 (Address) 1216 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	11-13 1929
20 UNDERTAKER A. J. Rusch	ADDRESS 5 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 50862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

×31 ✓

E 50862

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14-20 WARD)

2—FULL NAME Miss Agnes Ryan

(a) RESIDENCE NO. 815 West North Ave ST., WARD 11 Ga

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19 00

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) 048

(c) Name of employer

9 BIRTHPLACE (city or town) W Va
(State or country)

PARENTS

10 NAME OF FATHER James M Ryan

11 BIRTHPLACE OF FATHER (city or town) W Va.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Maguire

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant James M Ryan
(Address) 815 West North Ave

15 Filed ..... 19.. C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to Nov 9, 1929.

that I last saw h[illegible] alive on Nov 9, 1929

and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 7E yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyba, M. D.

11/9, 1929 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview W Va	11/11/29
20 UNDERTAKER Hope & Staley	ADDRESS Fulton & Fayette

Spec.—1-12-23—MAT—500 Blks.

E 50863 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50863
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3521 Hickory Ave ST., 13-53 WARD)

2-FULL NAME Jedekiah M. Tracey.

(a) RESIDENCE NO. 3521 Hickory Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Bertha M. Tracey.

6 DATE OF BIRTH (month, day, and year) Sept. 8th 1877.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 0 50

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Thomas S. Tracey.

11 BIRTHPLACE OF FATHER (city or town) Balto Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Nancy Burnham.

13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country) Md.

14 Informant Bertha M. Tracey Wife
(Address) 3521 Hickory Ave.

15 Filed Nov 12 1929. 19 W.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1929 to Nov 9, 1929 that I last saw h[illegible] alive on Nov 9, 1929 and that death occurred, on the date stated above, at 12.45 P.m.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach

(duration) yrs 6 mos ds.

CONTRIBUTORY (Secondary) Obstructive Icterus

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical findings

What test confirmed diagnosis?

(Signed) J. N. Wilson M. D.

11, 1929 (Address) 848 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Nov 12 1929

20 UNDERTAKER J. Walter Davis ADDRESS 3307 Kirk Ave

Spec.—1-10-21—MAT—1500 Nbs.

Carollis

E 50864 . HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50864

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mayfield & Kraft 9-17 ST., WARD)

2-FULL NAME Bertha Carollis

(a) RESIDENCE NO. Essex Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 23, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER John Carollis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Sciancalepore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant John Carollis (Address) Essex Md.

15 Filed NOV 1 1929 Day HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1929

17

I HEREBY CERTIFY, That I attended deceased from 10-21 . 1929 . to 11-10 . 1929 .

that I last saw her alive on 11-10 . 1929 .

and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Blumberg M. D.

19 (Address) 1 Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Nov. 11 1929

20 UNDERTAKER John G. Connelly

ADDRESS Essex Md

IION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Gotha

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50865

CERTIFICATE OF DEATH

105 E 50865

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 932 S. Eutaw ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna M. Gotha.

(a) RESIDENCE NO. 932 S. Eutaw ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Gotha

6 DATE OF BIRTH (month, day, and year) June 17th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Sofering.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna B. Ambrose.

(Address) 932 S. Eutaw St. Md

15 Filed 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9th 29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1929, to Nov. 9, 1929, that I last saw her alive on Nov. 9, 1929 and that death occurred, on the date stated above, at .. m.

The CAUSE OF DEATH* was as follows:

Chronic Asthmatic Bronchitis

(duration) do not know yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) T. B. Bronushas, M. D.

11-11-29, 19 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem — DATE OF BURIAL: Nov 12th 1929

20 UNDERTAKER: Lilly & Jailer Inc. — ADDRESS: 1038 W. Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50866

CERTIFICATE OF DEATH

159-002

E 50866

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 15-61 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Rosenberg

(a) RESIDENCE NO. 3513 Fairview Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nathan Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Merin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 11 1925 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1929, to Nov. 11, 1929, that I last saw her alive on Nov. 11, 1929 and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Heart

(duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Wass. & Lat. X-ray

(Signed) Harris M. McCrea, M. D.

11-11, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	11-11- 1929

20 UNDERTAKER Jack Lewis, ADDRESS 1439 E Balto. 25

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓

E 50867

E 50867.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 S. Streeper ST. 14-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walenty Poznaniak

(a) RESIDENCE NO. 807 S. Streeper St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ~~Unk~~ ~ 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Poznaniak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Poznaniak

(Address) 807 S Streeper St.

Filed NOV 12 1929 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9-29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1929, to Nov. 9, 1929, that I last saw him alive on Nov. 8, 1929 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum etc

(Signed) Eugene L. Pennington M. D.

Nov. 11, 1929 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Nov 12 1929

20 UNDERTAKER J W Ozazewski 1930 ADDRESS Easton Ave

Spec.—6-9-19—H. P Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50868

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

164 ✓

E 50868

REGISTERED NO.

CITY OF BALTIMORE: (No. 1425 Mount Royal Ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Winifred Spellman Corcoran

(a) RESIDENCE. No. 1425 Mount Royal Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Corcoran

6 DATE OF BIRTH (month, day, and year) Sept 2 1847

7 AGE	87	Years	2	Months	27	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Spellman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Higman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary G. Corcoran
(Address) 1425 Mount Royal Ave

15 Filed Nov 9, 1929 J. Fay JONES, M. D. Registrar

NOV 12 1929 C. H. Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/9/1929

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1929, to Nov 9, 1929, that I last saw her alive on Nov 9, 1929, and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) Months Days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough M. D.

, 19 (Address) 3923 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov 12 1929

20 UNDERTAKER ADDRESS

Mary A. Gauthrop 2839 Raynor Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50869

CERTIFICATE OF DEATH

101-001

E 50869

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Charles St. & Lake Ave. ST.; 27-48 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Luther M. R. Willis

(a) RESIDENCE NO. Charles St. & Lake Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 11 mos. 5 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Vogeler

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) 042

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George R. Willis

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hoskins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Sophie V. Willis

(Address) Charles St. & Lake Ave.

15 Filed DEC 1 2 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 9, 1929, that I last saw h[illegible] alive on Nov 9, 1929 and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 8 yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr. M. D.

Nov 11. 1929 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bloomfield	11/12 19 29
20 UNDERTAKER Henry U. Meyers & Son	ADDRESS 800 W Calvert

Cor.—10-10-29—A Co.—100 Bks.

E 50870

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50870

CERTIFICATE OF DEATH

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 407 N. Grmur St., 17-25 Ward)

2-FULL NAME Grace Centinco

(a) RESIDENCE NO. 407 N. Grmur St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 30 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 13 1927

7 AGE	Years	Months	Days	IF LESS than 1 day, hrs. or min.
	1	11	30	29.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph Centinco

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine Cammanta

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant Mr. J. Centinco
(Address) 407 N. Grmur St

15 Filed 12 1929 O. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Extensive body burns. 2nd degree. Fell in tub of hot water. Accidental death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

11/11. 1929. (Address) 2737 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 11/12 1929

20 UNDERTAKER Geo J. Ruth - 1735 Aisquith

ADDRESS

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50871

CERTIFICATE OF DEATH

188-103 E 50871

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp 8-16 Ward)

2-FULL NAME Micheal De Santis

(a) RESIDENCE NO. 2001 N. Rose St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write, the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec - 11 - 1918

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
10	10	10	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chief
(b) General nature of industry, business, or establishment in which employed (or employer) Public School
(c) Name of employer Augusto Orlando

9 BIRTHPLACE (city or town) Balto
(State or country) Italy

PARENTS

10 NAME OF FATHER Angelo DeSantis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Repuchlia

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Carroll Ward
(Address) 1539 N Broadst

15 Filed 19 HAMPSON JONES
Registrar

DEC 12 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract Skull—
boy ran from behind parked auto in front of moving automobile that ran over him (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptur Bl Kidneys (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Callington & Sinclair Lane

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) G. J. Krauss, M. D.

11, 19 29 (Address) 2939 W Eldon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Dec 2 19 29
20 UNDERTAKER	ADDRESS
Randall & Lippel	3006 Eden

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 50872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50872

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home St. 27-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Gordon

(a) RESIDENCE NO. Belvedere & Greenspring ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Gordon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hosp

(Address)

15 Filed DEC 1 2 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 9 1929 to Nov 11 1929, that I last saw h alive on Nov 11, 1929, and that death occurred, on the date stated above, at 4.15 p m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) ? Hypertension

(duration) yrs mos. da. 1

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Meyer Muller, M. D.

11/11, 1929 (Address) 3649 McElroy Ave

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 11/12 1929

20 UNDERTAKER Jack Levin 409 Eldon St

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 50873 — REGISTERED NO.

E 50873
1-PLACE OF DEATH

City of Baltimore: (No. 2413 E. Fairmount. Ave St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maltilda Wallach

(a) RESIDENCE NO. 2413 E. Fairmount Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Meyer Wallach

6 DATE OF BIRTH (month, day, and year)
April 17. 1855

7 AGE	Years	Months	Days 23	IF LESS than 1 day hrs. or min.
	74	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Samuel Hecht

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Henretta

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Stanley H. Wallach
(Address) 1301 W. Baltimore St

NOV 12 1929 — CLEARANCE JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192
Nov 10/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. H. Coen, M. D.

11/11, 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem	11. 12 19 29

20 UNDERTAKER Jack Levine, 1439 E Balto St — ADDRESS

important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50874

CERTIFICATE OF DEATH.

94-001 E 50874

1-PLACE OF DEATH

City of BALTIMORE: (No. 2528 E.Biddel ST. St. 8-12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes H.Weber

(a) RESIDENCE NO. 2528 E.Biddel St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew G.Weber

6 DATE OF BIRTH (month, day, and year) July 11/1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	3	28 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto.Md.

PARENTS

10 NAME OF FATHER Andrew Herrmann

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Wagner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Andrew Weber

(Address) 250 Monastery Ave.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) H.H.Cullen M. D.

(Coroner)

1/11/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. Date of Burial Nov. 13/29

20 UNDERTAKER Philip Sterzig ADDRESS 2016 Orleans St.

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50875

CERTIFICATE OF DEATH

129 ✓ E 50875

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 416 E.Biddel St. ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Phillip G.Williams

(a) RESIDENCE NO. 416 E.Biddel St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E.Simpson

6 DATE OF BIRTH (month, day, and year) Jan.8/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Chauffer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emelie--------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs.Mary E.Williams

(Address) 416 E.Biddel St.

15 Filed NOV 12 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10/29

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1928, to Nov 10, 1929, that I last saw him alive on Nov 10, 1929 and that death occurred, on the date stated above, at 11, 10P.M.

The CAUSE OF DEATH* was as follows:

Chr Interstitual Nephritis

from history about

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Thos P. Geraghty, M. D.

11/11/29 (Address) 2225 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem.

DATE OF BURIAL Nov 1929

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans St.

Spec.—2-20-28—L. F. S.—500 Blks.

E 50876 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 50876

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 631 N. Duncan St. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Bauer

(a) RESIDENCE NO. 631 N. Duncan St. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Feb. 25/1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Schloss & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Mathias Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Kemberling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Lizzie Bauer

(Address) 631 N. Duncan St.

15 Filed NOV 12 1929 J. HAMPTON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10/29

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 19 29, to November 10th, 19 29.

that I last saw h.. alive on November 10th, 19 29

and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Interst. Nephritis (duration) 7 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos. H. A. Mc Gee M. D.

11, 19 29 (Address) 1031 N. Caroline Str.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Nov. 13/29 19

20 UNDERTAKER Philip Sterne ADDRESS 2016 Orleans ST

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50877 -

CERTIFICATE OF DEATH.

11-24-38 E 50877

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md.

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell C. Williams

(a) RESIDENCE NO. 1123 Morris St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Williams

6 DATE OF BIRTH (month, day, and year) July 8, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas C. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Angeline Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

Filed DEC 2 1929 C. HAMPSON JONES, M. D. By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 9 19 29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 19 29, to Nov. 9, 19 29, that I last saw him alive on November 8, 19 29, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis, tertiary

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valv.disease of heart, aortic insufficiency unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. & clinical

(Signed) Ralph L. Porter, M. D.

11/9, 19 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U S NATIONAL CEM

DATE OF BURIAL 12/2 1929

20 UNDERTAKER Robert Brookseson

ADDRESS Calhoun Hollins

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

Dr Smink 4706 Hanford Ave Hamilton 0220

E 50878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

122-00

E 50878

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2912 Willax Ave ST. 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa R Mihue

(a) RESIDENCE NO. 2912 Willax Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Mayer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Mihue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara May Kratz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Matilda Mihue

(Address) 2912 Willax Ave

15 Filed NOV 12 1929 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929 to Nov 10, 1929, that I last saw h alive on Nov 10, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Carcinoma of liver with ascites.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Smink, M. D.

Nov 11 1929 (Address) 4706 Hanford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	11/13 1929
20 UNDERTAKER Wm Cook 1217	ADDRESS St Paul St

Cor.—10-10-29—A Co.—100 Blks.

Dutton

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 50879

CERTIFICATE OF DEATH

E 50879

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1528 Gorsuch Ave St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Donaldson L. Dutton

(a) RESIDENCE NO. 1528 Gorsuch Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Dutton

6 DATE OF BIRTH (month, day, and year) Aug 9/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	01	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer John E Hurst

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin L. Dutton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa A. Burnston

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Matilda M. Dutton
(Address) 1528 Gorsuch Ave

15 Filed ... By ... Registrar

OV 12 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10-29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) J. H. Wilson, M. D.

11/11/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 11/12 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Young 729 Washington Blvd Cal 2529

E 50880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 50880

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Mt Royal Ave ST. 11-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Culbertson

(a) RESIDENCE NO. 1212 Mt Royal Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Culbertson

6 DATE OF BIRTH (month, day, and year) May 13, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Tiss T. Chance

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Slaughter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nora W Blake

(Address) 1321 Fayette St

15 Filed NOV 12 1929, 19 H. HAMPTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Nov 10, 1929, that I last saw h[illegible] alive on Nov 10, 1929 and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Apoplexy x

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stanley Stragg, M. D.

Nov 11, 1929 (Address) 729 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	11/13 1929
20 UNDERTAKER Wm Cook 1207	ADDRESS St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 5088I

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 50881

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2529 Madison Ave (WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Robinson

(a) RESIDENCE NO. 2529 Madison Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Robinson

6 DATE OF BIRTH (month, day, and year) May 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co

PARENTS

10 NAME OF FATHER Thomas Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Gertrude Thomas

(Address) 2529 Madison Ave

15 Filed ....., 19 ..... Registrar

1 2 1929 FRANCIS JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1929, to Nov 11, 1929, that I last saw h alive on Nov 11, 1929 and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis, chronic

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) age - arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? h

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine + Symptoms

(Signed) Wm. H. Wright, M. D.

11/12, 1929 (Address) 1209 Pritchard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westwood DATE OF BURIAL Nov 15th 1929

20 UNDERTAKER Thomas E Wright ADDRESS 3647 Cary

Spec.—8-16-29—L. F. S.—100 Bks.

E 50882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 50882

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 1843 Fairmount Ave. WARD 15-21

2—FULL NAME James Stansbury

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1843 Fairmount Ave.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J. Stansbury

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 53; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Stansbury

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliza Powell

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md

14 Informant: Mary J. Stansbury
(Address) 1843 Fairmount

15 Filed ... 19 ... Registrar

NOV 12 1929 H. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 10/29

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to Nov 10, 1929, that I last saw him alive on Nov 9, 1929, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ... (duration) ... yrs. ... mos. ... ds.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam'n

(Signed) Frank E. Wagner M. D.

Nov 10, 1929 (Address) 1086 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL Nov 13th 19 29

20 UNDERTAKER: Edmund D. Wright — ADDRESS 864 N. Carey

Spec.—I-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

50883

CERTIFICATE OF DEATH.

161-001 E 50883

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 S Hanover St. WARD) 42-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Russell & Gladys Thomas 8 mo.

(a) RESIDENCE No. 600 S Hanover. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Nov 10, 1928

7 AGE — Years: no | Months: no | Days: no | If LESS than 1 day 16 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Russell Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ill

12 MAIDEN NAME OF MOTHER: Gladys Trivilian

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Gladys Thomas (Address) 600 S Hanover

15 Filed NOV 12 1928 E. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11 1928

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1928, to Nov 11, 1928, that I last saw him alive on Nov 10, 1928, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows: Premature Birth 8 mo

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Congenital Debility

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lungs

(Signed) R U Slaton, M. D.

Nov 11, 1928 (Address) 2208 Bullitt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet — DATE OF BURIAL Nov 12 19

20 UNDERTAKER Knell & Sc — ADDRESS 917 Madison

NOV 12 1928

HOW IS very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 50884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50884

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Lakedrive apts ST. 13-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Rosenfeld

(a) RESIDENCE NO. Lakedrive apts ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Rosenfeld

6 DATE OF BIRTH (month, day, and year) Jan 30 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Australia

PARENTS

10 NAME OF FATHER Simon Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Eisenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr A. Kaufmann

(Address) Fed Bank Apts.

15 Filed 11 21 1929 H. LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1928, to Nov 11th, 1929, that I last saw h[illegible] alive on Nov 11th, 1929, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Chr. Vulvular disease, Pyo-nephrosis

(duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation, Pulmonary Edema.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? clinical findings—

(Signed) Michael A Abrahe, M. D.

Nov 11, 1929 (Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem

DATE OF BURIAL 11/13 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50885

CERTIFICATE OF DEATH

44 E 50885

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD) 2-44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William algernon Percy

(a) RESIDENCE NO. Vienna Md. ST., WARD Vienna Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 4 ds. How long in U. S., If foreign birth? 68 yrs. 1 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ellen Percy

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1861

7 AGE	Years	Months	Days 26	If LESS than 1 day, hrs. or min.
	68	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Algernon Sydney Percy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ellen Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William algernon Percy

(Address) Vienna Md.

15 Filed DEC 12 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1929 to Nov. 11, 1929

that I last saw h[illegible] alive on Nov. 11, 1929

and that death occurred, on the date stated above, at 5 52 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.
Post-operative

(duration) yrs. 8 mos. de.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs mos. 1 de.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? Yes Date of Nov. 9.

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray Exam.

(Signed) Samuel McLanahan, M. D.

Nov. 11, 1929 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Vienna Md.	Nov 13 1929.

20 UNDERTAKER Stewart Monn Co ADDRESS Balto.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50886

45 ✓

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2207 Roslyn Ave ST. 15-61 WARD)

REGISTERED NO. E 50886

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Foss Owen

(a) RESIDENCE NO. 2207 Roslyn Ave ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 17 ds. How long in U. S., if foreign birth 69 yrs. 3 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Krebs Owen

6 DATE OF BIRTH (month, day, and year) July 27 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Ins. Co

(b) General nature of industry, business, or establishment in which employed (or employer) Transportation

(c) Name of employer Sup't B. & O. R.R.

9 BIRTHPLACE (city or town) Balto.

(State or country) Maryland

PARENTS

10 NAME OF FATHER George F. Owen

11 BIRTHPLACE OF FATHER (city or town) Hertford

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Aler

13 BIRTHPLACE OF MOTHER (city or town) Reisterstown

(State or country) Maryland

14 Informant Mrs. Mary K. Owen-wife

(Address) 2207 Roslyn Ave

15 Filed NOV 12 1929, 19 H. TAYLOR JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Nov 10, 1929, that I last saw him alive on Nov. 10, 1929 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid.

(duration) One yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial collapse

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Freeman F. Sherman, M. D.

19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Nov 13 1929
20 UNDERTAKER	ADDRESS
Stewart & Conn Co	Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50887

CERTIFICATE OF DEATH

E 50887

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2801-N-Calvert ST. 12-50 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Jean Speller

(a) RESIDENCE NO. 2801-N-Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 0 ds. How long in U. S., if foreign birth 25 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Newman W. Speller

6 DATE OF BIRTH (month, day, and year): Aug-7-1849

7 AGE: Years 80 | Months 3 | Days 4 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): Toronto

(State or country): Canada

PARENTS

10 NAME OF FATHER: Thos. Carfrae

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country): Scotland

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country): Scotland

14 Informant: Mrs Marshall K. McCord (daughter)

(Address): 2801-N-Calvert St

Filed: NOV 12 1929

CHAMPION JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to Nov 11, 1929

that I last saw h w alive on 9:30 AM 11/11/ 1929

and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pylorus

Present at myfirst visit

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Fecal Carcinomatosis & Uro Senile Cardiac debility

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Carcinoma evaluated

(Signed) Chas Chuidl, M. D.

, 19 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Toronto-Canada	Nov-12 1929.
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto.

Spec.—1-12-23—M&T—500 Bks.

E 50888

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50888

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. Caton & Wilkens Aves St. 25-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Bodensick

(a) RESIDENCE No. 2826 Wisel St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Annie M. Bodensick

6 DATE OF BIRTH (month, day, and year) Nov. 22 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	73	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elmer Bodensick

(Address) 2501 Keller St

15 Filed DEC 2 1929 C. HALEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-30, 1929, to 11-10, 1929

that I last saw him alive on 11-10, 1929

and that death occurred, on the date stated above, at 11 20 a. m

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11-8-29

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Percival Nickell, M. D.

11/10, 1929 (Address) 2157 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	Nov. 13 1929

20 UNDERTAKER George L. Schwabb ADDRESS 2101 Eutaw Ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50889

CERTIFICATE OF DEATH.

167-001

E 50889

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 437-01 24th St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Beckford

(a) RESIDENCE NO. 437-01-24th St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter H Beckford

6 DATE OF BIRTH (month, day, and year) Augt 56

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER Wm Richey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Vance

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant John H Stansbury

(Address) 437 N 24 St

NOV 12 1929

Filed ..... J. MADDY JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Lacerated Con.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

(Coroner)

11/11 1929 (Address) 1932 Orlando

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Balto County	Nov 12 1929

20 UNDERTAKER	ADDRESS
W M Routson	2238 W Balto

very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50890 — CERTIFICATE OF DEATH — 1052 — E 50890

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 948 W. Lombard St. ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patrick Hamberry

(a) RESIDENCE NO. 1629 Wilkens Ave., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16,1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	25 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Hamberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Donohue

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mary Birmingham

(Address) 1737 Wilkens Ave.,

15 Filed NOV 12 1929 HAMPSON BOYCE M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10,1929

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1929, to November 9, 1929, that I last saw h im alive on November 9, 1929 and that death occurred, on the date stated above, at 7.45 A.m.

The CAUSE OF DEATH* was as follows:

Empysenia 3 Yrs.
Chronic Asthma

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dulitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. Nevolaham M. D.

11/11, 1929 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	11/13 1929

20 UNDERTAKER — ADDRESS

John Cowen & Son 901 Hollins St.

Spec. 1-10-21—M&T—1500 Blks.

E 50891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50891

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Gilmor Hospital) REGISTERED NO.

2-FULL NAME Mrs Mary E Phelps (Wife of Harry) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2707 Riggs Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry S Phelps

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 37; Months 7; Days 1; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Adam Bitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Grimm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Hooper Rigbie

15 Filed 11-12-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-11-29

17 I HEREBY CERTIFY, That I attended deceased from 11-1-29, 19 , to 11-11-29, 19 , that I last saw h alive on 11-11-29, 19 , and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Primary) (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Contributory Peritonitis (duration) yrs. 1 mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? 11-7-29 Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemy

DATE OF BURIAL: Nov 14 1929

20 UNDERTAKER: Jos Joerdens Son

ADDRESS: 2078 E. Pr

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50892 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50892

CERTIFICATE OF DEATH. 131

1-PLACE OF DEATH Maryland General Hosp REGISTERED NO.

CITY OF BALTIMORE: (No. Howard & Madison ST., 15-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Demuth

(a) RESIDENCE NO. 3018 Glyndon Falls Pkway ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Johanna Demuth

6 DATE OF BIRTH (month, day, and year) May 31, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	11 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Fred H. Demuth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Prang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp. Record (Address)

NOV 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 10 1929 to Nov 11 1929, that I last saw him alive on Nov 11 1929, and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows: Pyonephrosis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Uremia Coma (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) [illegible] M. D.

11/11, 1929 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Nov 13 1929
20 UNDERTAKER	ADDRESS
Jos Jacobs Son	2173 Pa

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 50893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 50893

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. N.S. Shore Line 12 W Westport, Balto. Md. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Sheldon Cox

(a) Residence No. 924 Burgundy St. St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white.	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Leroy Cox.

6-DATE OF BIRTH (month, day and year) Oct 4, 1898

7-AGE. 31 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Walter Welling

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Sarah E Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md.

14- (Informant) Sarah E Welling

(Address) 924 Burgundy St

15-

Filed NOV 12 1929 HARRISON JONES Registrar,

Dat

INSTRUCTIONS ON BACK OF CERTIFICATES.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Nov. 9, 1929

17- I HEREBY CERTIFY, That I attended deceased from Aug 25, 1929 to Nov 9, 1929

that I last saw h alive on Nov. 9, 1929

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(Duration) 1 yrs. mos. ds

CONTRIBUTORY (Secondary) cardiac failure

(Duration) yrs. mos. 10 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests,

(Signed) George A Kupjp M. D

11/10. 1929 (Address) 3030 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Nov. 12 1929
20-UNDERTAKER Joseph B Cook	ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

Ethel Liss ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50894

31

CERTIFICATE OF DEATH

E 50894

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 12-51 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Liss

(a) RESIDENCE NO. 2800 Remington ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Liss

6 DATE OF BIRTH (month, day, and year) Dec. 30 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39 40		10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Bergan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records
(Address)

15 Filed NOV 12 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1929, to Nov. 11, 1929, that I last saw her alive on Nov. 11, 1929 and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Arnold Jr. M. D.

11-11, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	11/12 1929

20 UNDERTAKER Abel Levinson & Bro ADDRESS 1127 E Balto st

Spec.—1-18-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50895

CERTIFICATE OF DEATH.

E 50895

118-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 27-4th (WARD)

2-FULL NAME Herman H. Poske

(a) RESIDENCE NO. 270 Gibbons Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Margaret Poske

6 DATE OF BIRTH (month, day, and year) May 28 - 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	47	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer) City 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Mrs Poske

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Margaret Buchman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Margaret Poske

(Address) 270 Gibbons Ave

15 Filed 1929 . 19 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-4- , 19 29 , to 11-9- , 19 29.

that I last saw him alive on 11-9-29 , 19 .

and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebellar hemorrhage

(duration) 3 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 11-5-29 11-7-29

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H B Runsing, M. D.

19 Address Saint Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park — DATE OF BURIAL: Nov. 12, 1929

UNDERTAKER: Wm J Dickinson & Son — ADDRESS: North Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50896

CERTIFICATE OF DEATH

84

E 50896

1—PLACE OF DEATH

REGISTERED NO. 15-60

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2104 Clifton Av ST., WARD)

2—FULL NAME Mrs Agnes D. Broadfoot

(a) RESIDENCE NO. 2104 Clifton Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Wht	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of George Scott Broadfoot

6 DATE OF BIRTH (month, day, and year) Dec 12th 1847

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	81	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assisted with Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer —

9 BIRTHPLACE (city or town) Haddington
(State or country) Scotland

PARENTS

10 NAME OF FATHER Wm. Drysdale

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Golden

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant Wm Broadfoot
(Address) 2104 Clifton Av

15 Filed Nov. 14, 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 12, 1929, that I last saw her alive on Nov 12, 1929 and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
(Sclerotic Arteries)

One hour.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Age, with failing powers
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consumption

(Signed) E Barnett, M. D.

11/12, 1929 (Address) 1605 N. Norfolk Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Nov. 14, 29
UNDERTAKER	ADDRESS
Wm J Tuckner Son	U. Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50897

CERTIFICATE OF DEATH

90

E 50897

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1829 W Fairmount Ave (St.) 20-27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily A Davis

(a) RESIDENCE NO. 1829 W Fairmount Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J Davis

6 DATE OF BIRTH (month, day, and year) Sept 28 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54	53	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Kent County Md

PARENTS

10 NAME OF FATHER John W Rodney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentley Md

12 MAIDEN NAME OF MOTHER Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant William J Davis

(Address) 1829 W Fairmount Ave

15 Filed NOV 1929 H. M. BOWERS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 1- 1929, to Novembr 10 1929 that I last saw h W alive on Novembr 10 1929 and that death occurred, on the date stated above, at 730 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure Edema

(Signed) Chas A Corbin M. D.

11/11, 1929 (Address) 2105 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall Md	Nov 13 1929
20 UNDERTAKER Vernon Lechner	ADDRESS Hadin

Cor.—10-10-29—A Co.—100 Bks.

E. 50898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E. 50898

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp. St. 17-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alston Allen Perry

(a) RESIDENCE No. 2500 Maryland. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1 - 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	63	1	11 10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Butte Mont
(State or country)

PARENTS

10 NAME OF FATHER Alston Perry

11 BIRTHPLACE OF FATHER (city or town) Butte Mont
(State or country)

12 MAIDEN NAME OF MOTHER Anne Stow.

13 BIRTHPLACE OF MOTHER Butte Mont.
(State or country)

14 Informant C. Perry
(Address) 1803 Eutaw Pl.

15 Filed DEC 1 1929 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Emphysema
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Femur. Fell down steps
(duration) yrs. mos. 13 ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular

(Signed) F. B. Lauck, M. D.
Nov 11 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Nov 13 1929

20 UNDERTAKER Henry H. Jenkins & Co

ADDRESS Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 50899

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3916 Fait ave ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T. Knight

(a) RESIDENCE NO. 3916 Fait ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella M. Knight

6 DATE OF BIRTH (month, day, and year) Aug. 31-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crane Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Dash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Estella M Knight

(Address) 3916 Fait ave

15 Filed DEC 1 1929 19.. E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1928, to Nov 10, 1929, that I last saw him alive on Nov 10, 1929, and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation.

Myocarditis.

(duration) 1 yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Jno. D. Clift, M. D.

11/11, 1929 (Address) 3532 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn cem — DATE OF BURIAL Nov 14 1929

20 UNDERTAKER George W. Zibbell — ADDRESS 1737 E. Eager st

Spec.—2-29-28—L. F. S.—500 Blks.

E 50900

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128 E 50900

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3103 Fleet ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry J. Fischer

(a) RESIDENCE NO. 3103 Fleet ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Caroline J. Fischer

6 DATE OF BIRTH (month, day, and year) Nov 22-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant Caroline J. Fischer

(Address) 3103 Fleet St

15 Filed DEC 2 1929, HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 1929 to Nov 9 1929

that I last saw him alive on 19 29

and that death occurred, on the date stated above, at 11 15 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Levinson M. D.

11-12-1929 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Nov. 14 1929
20 UNDERTAKER	ADDRESS
George W. Zinkler	173 E. Eager st

Spec.—2-29-28—L. F. S.—500 Bks.

E 50901 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50901

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Lyndenham Hospital 9-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Tragesser

(a) RESIDENCE NO. 2201 Lake Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. 5 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Tragesser

6 DATE OF BIRTH (month, day, and year) June 15, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broom-maker

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ben Tragesser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry Leggett

(Address) 2201 Lake Ave

15 Filed NOV 2 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1929, to Nov 10, 1929, that I last saw h alive on Nov. 10, 1929 and that death occurred, on the date stated above, at 8:12 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 0 3(?) yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Bronchial) & Streptococcus Cellulitis (duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Hoby M. D.

11-11 1929 Address Lyndenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	11/13 1929
20 UNDERTAKER	ADDRESS
Chas. T. Graul Sons	1807 N. Gay St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50902

CERTIFICATE OF DEATH.

90 E 50902

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Wickham Rd ST. 8 WARD)

2-FULL NAME Mary Virginia Willingham

(a) RESIDENCE NO. 7 Wickham Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William E Willingham

6 DATE OF BIRTH (month, day, and year) May 2 1872

7 AGE Years 57 Months 6 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Maud L. Bell. (Address) 7 Wickham Rd

Filed NOV 12 1929 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 19 29

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929 to Nov 11, 1929

that I last saw h alive on Jan 10, 1929

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Mitrial Regurgitation

Interstate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. L. Campbell M. D.

11. 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL Nov. 14 19 29

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50903

CERTIFICATE OF DEATH

129

E 50903

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Hack

(a) RESIDENCE NO. 634 Redwood, West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Hack

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Hack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Esther ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed NOV 12 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1929, to Nov. 8, 1929, that I last saw him alive on Nov. 8, 1929 and that death occurred, on the date stated above, at 8 A. M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Acute

(duration) over yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis, chronic Acute

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.E. Lab. Autopsy

(Signed) Harvin M. McLean, M. D.

11-10, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov. 12, 1929
20 UNDERTAKER	ADDRESS
Mrs Katie R. Williams	3229 Schroeder St

Spec.—9-29-28—L. P. S.—600 Blks.

E 50904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 50904

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 9-N-6 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leroy Palmer

(a) RESIDENCE NO. 2340 Boone st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
(h)USBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. E. Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 1 2 1929, 19 4054 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1929, to Nov. 6, 1929, that I last saw h.im alive on Nov. 6, 1929, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) [signature] M. D.

11-6, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: NS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS

NOV 12 1929

HAMPSON JONES, M.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50905

CERTIFICATE OF DEATH

90 E 50905

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 4-24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Morrison

(a) RESIDENCE NO. 304 Camel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elias Morrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria Woodyard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed NOV 12 1929 H. HANLEY JONES M. D. Registrar

4053

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 9, 1929 to Nov. 7, 1929

that I last saw him alive on Nov. 7, 1929

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Toxic

over

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist. & C. Lab.

(Signed) Warren M. McLean, M. D.

11-10, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER (Commissioner Health.)

ADDRESS NOV 12 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50906

CERTIFICATE OF DEATH

31 E 50906

1—PLACE OF DEATH Baltimore City Hospitals (2B24) REGISTERED NO. 1724

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Wilson

(a) RESIDENCE NO. 590 St. Mary's st. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Hattie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Hospital Records

(Address) .....

15 Filed NOV 12 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to Nov. 6, 1929, that I last saw him alive on Nov. 6, 1929 and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. E. Arnold Jr. M. D.

11-6, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health — ADDRESS NOV 12 1929

Spec.—1-10-21—M&T—1500 Blks.

50907.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50907.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Parkdale ST. 25-22 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nelson Samis

(a) RESIDENCE NO. 1910 Parkdale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U. S., if of foreign birth? 48 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Mary Alice Samis

6 DATE OF BIRTH (month, day, and year) January 13, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	10	2 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Md

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Ebenezer Samis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER ——— ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ———

14 Informant Ethel Mavil (Address) 1910 Parkdale

15 Filed DEC 2 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to November 11, 1929, that I last saw him alive on November 11, 1929, and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Prostatic Hypertrophy. (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of ———

Was there an autopsy? No

What test confirmed diagnosis? Clerical

(Signed) Wm A Straus, M. D.

11/12, 1929 (Address) 1901 Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carlton Md. DATE OF BURIAL 11-13 1929

UNDERTAKER Daniel Carlton ADDRESS Ba ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50908

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. 6007 York Road ST. 27-48 90 (A.D.)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Louise Smith

(a) RESIDENCE No. 6007 York Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Smith

6 DATE OF BIRTH (month, day, and year) Sept. 30. 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. 609

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Black and Decker

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Hill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Sophia Garner.

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany.

14 Informant Robert Brookes

(Address) 172 Calhoun St

DEC 1 2 1929 C. HAMPSON JONES, M. D.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1929, to Nov. 12, 1929, that I last saw her alive on Nov. 12, 1929, and that death occurred, on the date stated above, at 8 15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis. - 5 yrs.
Acute Bacterial Endocarditis.

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Tests.

(Signed) ..... M. D.

11-12 1929 (Address) 6014 York Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	11/14 1929
20 UNDERTAKER	ADDRESS
Robert Brookes Son	Calhoun & Collins

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 50909 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 50909

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 819 Woodward St. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elwood Greenfield

(a) RESIDENCE NO. 819 Woodward ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Susie Greenfield

6 DATE OF BIRTH (month, day, and year) March 12, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frankinville Md

PARENTS

10 NAME OF FATHER A. H. Greenfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rhoda Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Miss Lucy Greenfield

(Address) 1838 W Fayette St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1929, to Nov 11, 1929, that I last saw him alive on Nov 10, 1929, and that death occurred, on the date stated above, at 10. a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. d. o'neill, M. D.

11/14 1929 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	11-13 1929
20 UNDERTAKER Robt Brooks & Son	ADDRESS Cathedral & Hollins St

NOV 12 1929 C. HAMPSON JONES, M. D. Registrar

BY

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50910

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50910

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 E. Lombard St.) (1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A. Pearman

(a) RESIDENCE NO. 2117 E. Lombard St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Pearman

6 DATE OF BIRTH (month, day, and year) May 31, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70.	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Hahn Bakery.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Carter Pearman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Pearman

(Address) 2117 E. Lombard St.

15 Filed 12 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1929, to Nov 10, 1929, that I last saw h alive on Nov 10, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar Bronchial.

(duration) 5 mos. 5 da.

CONTRIBUTORY (Secondary) Arterio Sclerosis Myocarditis

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W J Gunn, M. D.

11/12/29 (Address) 622 W. Mosher Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Nov. 13, 1929

20 UNDERTAKER John A. Moran — ADDRESS 3006 E. Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50911 ✓ 31 E 50911

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S. Bond St. ST. 34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter Marcinko

(a) RESIDENCE NO. 414 S. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~None~~

6 DATE OF BIRTH (month, day, and year) Unk. 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanly Marcinko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Pawelczyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanly Marcinko

(Address) 414 S Bond St

15 Filed 2-1929, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1929

17 I HEREBY CERTIFY, That I attended deceased from July 25, 19 29 to Nov 10, 19 29.

that I last saw him alive on Nov 10, 19 29.

and that death occurred, on the date stated above, at 10. A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shell Shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. W. Schemenk, M. D.

19 (Address) 1337 S Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Nov.	14 1929
20 UNDERTAKER F. W. Ozazewski 1930	ADDRESS Eastern Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50912

CERTIFICATE OF DEATH.

1837 E 50912

1-PLACE OF DEATH

City of BALTIMORE: (No. 318 E. Fernbrook Rd. Ward 8)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Pollock

(a) RESIDENCE NO. 318 E. Fernbrook Rd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, 1916

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	13	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City.

(State or country)

PARENTS

10 NAME OF FATHER Karl G. Pollock

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Indiana

12 MAIDEN NAME OF MOTHER Anna F. Timmerman

13 BIRTHPLACE OF MOTHER (city or town) City

(State or country)

14 Informant Karl Pollock

(Address) 327 E. Fernbrook Rd.

15 Filed 2 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Gun Shot wound Through Heart

Accidental

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

(Signed) John Morrissey M. D.

(Coroner)

11/12. 1929 (Address) 3632 Rolandene

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — Date of Burial Nov 13 1929

20 UNDERTAKER John A. Moran — ADDRESS 520 E. Balto

Of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50913

CERTIFICATE OF DEATH

X 183 E 50913

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital No. 37 St. Ward)

2-FULL NAME John H. Kellner

(a) RESIDENCE NO. 228 North Point Rd St. Balto. Co. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26/1914

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	14	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Attendant
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer ...

9 BIRTHPLACE (city or town) Balto Co.
(State or country)

PARENTS

10 NAME OF FATHER George Kellner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elsie Goetz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant George Kellner
(Address) 228 North Point Road

15 Filed 2 1929 C. HAMPSON JONES, M. D. Registrar
By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot
Gun Shot Wound of Chest
Revolver

(duration) ... yrs. ... mos. — ds.

CONTRIBUTORY (Secondary) Shock

(duration) ... yrs. ... mos. — ds.

18 Where was disease contracted If not at place of death? —

Did operation precede death? No Date of —

Was there an autopsy? — —

What test confirmed diagnosis? —

(Signed) H. G. Bladel M. D.

(Address) 43 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Nov 14 1929

20 UNDERTAKER Lilly & Zeiler Inc ADDRESS 403 S Wolfe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cer.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 50914

E 50914

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 18 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lessie Johnson

(a) RESIDENCE NO. 212 Stockton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Johnson

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Geo Thomas

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Lessie Johnson

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Wm F Estuck
(Address): 804 N. Bond

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar
DEC 1 2 1929
Per .....

CORONER'S CERTIFICATE OF [illegible]

16 DATE OF DEATH (month, day and [illegible]): Nov 11 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) five hours

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. C. Guick, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	11/13/29
20 UNDERTAKER	ADDRESS
Mrs Geo. H Holland	1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 50915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 50915

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2416 Stockton ST. (5-59 WARD)

2-FULL NAME William J. Morse

(a) RESIDENCE. No. 2416 Stockton ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice

6 DATE OF BIRTH (month, day, and year): 3 1904

7 AGE: Years 25; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: William J. Morse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Maffie Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Maffie Morse

15 Filed 12 1929 19

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 11 1929

17 I HEREBY CERTIFY, That I attended deceased from July 6 1929 to Nov 11 1929, that I last saw h[illegible]ve on Nov 11 1929, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis (Acute)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed W. J. Coleman M. D.

19 (Address) 2039 Mc Culloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mayfield Matthew Co. Va.

DATE OF BURIAL: 11/13/ 1929

20 UNDERTAKER: Mrs. Les. H. Holland

ADDRESS: 1601 Druid Hill

IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50916

CERTIFICATE OF DEATH

129 E 50916

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 615 N Calhoun ST. 16-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rev Frank R. Williams

(a) RESIDENCE NO. 615 N Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Lula

6 DATE OF BIRTH (month, day, and year) ? 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
65	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lula Williams

(Address) 615 N. Calhoun St.

Filed NOV 12 1929, 19

C. HAMPSON JONES, M. D.

Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 29 to Nov 11, 19 29

that I last saw him alive on Nov 10, 19 29

and that death occurred, on the date stated above, at 5 45 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Cat Lacey, M. D.

19 (Address) 1717 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	11/14/1929
UNDERTAKER Geo. Geo. H. Holland	ADDRESS 1631 Druid Hill

Important: See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50917

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 108 E 50917

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm Foreman

(a) RESIDENCE NO. 102 Shipley Ave ST., Catonsville Md. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roberta

6 DATE OF BIRTH (month, day, and year) ? 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab. Out

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Annes Co Md.

PARENTS

10 NAME OF FATHER Wm. Foreman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Roberta Foreman

(Address) 102 Shipley Ave

15 Filed DEC 2 1929, 19 C. HAMPSON JONES, Registrar

By RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11-29

17 I HEREBY CERTIFY, That I attended deceased from 11-9, 19 29, to 11-11, 19 29, that I last saw h alive on 11-11, 19 29 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unk

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) B Hamm, M. D.

11/12, 19 29 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hope, Md.	11/15/1929

20 UNDERTAKER Wm. Geo. H. Holland ADDRESS 1603 Druid Hill

Instructions. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E. 50918 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 50918

16-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 S. Curley ST. 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delores Maciolek

(a) RESIDENCE NO. 701 S. Curley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7 8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER John Maciolek

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Mary Starka

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant John Maciolek

(Address) 701 S Curley St

15 Filed 1 3 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 10- 1929, to Nov 11, 1929, that I last saw her alive on Nov - 11 - 1929 and that death occurred, on the date stated above, at 1130P m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. J. Davidson, M. D.

, 19 (Address) 3035 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem DATE OF BURIAL Nov 14 1929

20 UNDERTAKER Stephen J. Trulkowski ADDRESS 1005 Hanover

TION is very important See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50919 — 105 — E 50919

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 408 Whitridge Ave. St.) 17-50 (WARD)

2-FULL NAME Frank P. Ray

(a) RESIDENCE. No. 408 Whitridge Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida A Ray

6 DATE OF BIRTH (month, day, and year) Aug 29-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	2	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Welsh Cons. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida A Ray
(Address) 408 Whitridge Ave

15 Filed NOV 13 1929 19 H. C. HARRISON JONES, M. D. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct 31 1929, to Nov 11 1929, that I last saw h[illegible] alive on Nov 10 1929, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma
(duration) yrs. 1 mos 12 ds.

CONTRIBUTORY (Secondary) Nephritis
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H W Seltzer, M. D.
Nov 11 1929 (Address) 4900 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Baltimore Cemetery Nov 14 1929

20 UNDERTAKER — ADDRESS
Franklin W Seltz 709 W 33rd St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50920

CERTIFICATE OF DEATH.

× 188-001 E 50920

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Univ Hosp St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jonathan Kendall Clark

(a) RESIDENCE NO. Clark Sta-A.A.Co Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12-1884

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	45	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or esinblishment in which employed (or employer) Farm

(c) Name of employer Self

9 BIRTHPLACE (city or town) Clark

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph I Clark

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Maryann Pumphrey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant James B Clark

(Address) Clark Md

15 Filed ....., 19 ..... HARRISON JONES, M. Registrar

By: .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushed Chest Concussion chest = auto he was driving struck by train of a Boat

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fractured Skull Fract Humerus comp - Left

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. J. Fraser M. D. (Coroner)

11/12/29 (Address) 5939 mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

(Where was disease contracted, if not at place of death?) Clark Sta A A Co

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship Cem Date of Burial Nov 13 1929

20 UNDERTAKER J. Pickett Sons ADDRESS Towson Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Watkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50921

185

E 50921

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 23-54

CITY OF BALTIMORE: (No. 2908 Auchentoroly ST. (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Regina Watkins

(a) RESIDENCE NO. 2908 Auchentoroly ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 81 yrs. 8 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fmale	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard E Watkins

6 DATE OF BIRTH (month, day, and year) Mar-11-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Albatha Forrest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Mrs Parlett

(Address) 2908 Auchentoroly Terrace

15 Filed C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-11-1929.

17 I HEREBY CERTIFY, That I attended deceased from nov 1, 1929. to nov 11, 1929.

that I last saw he alive on nov 10, 1929

and that death occurred, on the date stated above, at 3.20 A m.

The CAUSE OF DEATH* was as follows:

Suppurated Fracture Right Hip

(Contributory) Senile Debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) John L. Thurland M. D.

11/12 1929 (Address) 1219 Eoplaw Lane N.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Nov 3 1929
20 UNDERTAKER W. J. Eichner & Sons	ADDRESS North Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50922

CERTIFICATE OF DEATH

31 ✓ E 50922

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Brunt ST. 14th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Rees

(a) RESIDENCE NO. 1421 Brunt ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Rees

6 DATE OF BIRTH (month, day, and year): May 30 1880

7 AGE — Years: 49 | Months: 5 | Days: 11 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cambridge Md.

PARENTS

10 NAME OF FATHER: Samuel Rees

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Margaret Rees

(Address) 1421 Brunt St.

15 Filed 13 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/11/29

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1929, to Nov. 11, 1929, that I last saw him alive on Nov. 9, 1929, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

General Exhaustion

about

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 3 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Impressio M. D.

11/13, 1929 (Address) 1017 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: 11-14 1929

20 UNDERTAKER: George L. A. Gibson — ADDRESS: 1733 Druid Hill Ave

Instructions: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50923

CERTIFICATE OF DEATH

90 ✓

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. E 50923

CITY OF BALTIMORE: (No. ____ ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lee Moore

(a) RESIDENCE NO. 219 Colvin ST., ____ WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0+0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10 NAME OF FATHER Roy Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 11 3 1929, H. HANSON JONES, M. D. Registrar

Per ____

Important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 16, 1929, to Nov. 10, 1929, that I last saw him alive on Nov. 10, 1929 and that death occurred, on the date stated above, at 6:10 A. m.

The CAUSE OF DEATH* was as follows:

Thrombosis Cerebral, Middle cerebral artery

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, chronic Nephritis, chronic (duration) over yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home & Care

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & Lab. Autopsy

(Signed) Harris Gill Wilson, M. D.

11/1, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	11-13 1929
20 UNDERTAKER	ADDRESS
Byron Knight	1218 N. Caldeson St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

230590 E 50924

31 ✓ E 50924

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-13 WARD)

2—FULL NAME Paul Dixon

(a) RESIDENCE NO. 1213 E Eden St (Usual place of abode) McElderry St Between Dallas & Caroline ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 27 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year) 5-14-26

7 AGE — Years: 3 | Months: 6 5 | Days: 27 26 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Carroll Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz Money

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 13 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-10-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1929, to Nov 10, 1929, that I last saw him alive on Nov 10, 1929 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Hemoptysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Tuberculin & Autopsy.

(Signed) J. V. Buckland Jr. M. D.

11/11, 1929 (Address) 1111 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: 11-13 1929

20 UNDERTAKER: Bynon & Wright ADDRESS: 1218 N. McElderry St.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 50925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1917 E 50925

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. President Hosp. St. 14-20 Ward)

2-FULL NAME Clovis Wyatt.

(a) RESIDENCE NO. 524 Robert St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Wm Wyatt

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Linkie Green

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Ruth Wyatt
(Address) 524 Robert St

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 10th 192 7

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Homicide)
Hemorrhage due to pistol wound of thorax

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What lest confirmed diagnosis? Douglas

(Signed) H. L. Smith M. D.

Nov 12 (Address) Bruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11/13 1927
20 UNDERTAKER	ADDRESS
Samuel Townley	578 N Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Eks.

E 50926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 50926

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N Stricker ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A McElmer

(a) RESIDENCE NO. 711 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER John McElmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia A Cromwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Cromwell

(Address) 711 N Stricker St

15 Filed 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11-29

17 I HEREBY CERTIFY, That I attended deceased from 11-9 1929 to 11-11 1929, that I last saw h alive on 11-10- 1929 and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & Symptoms

(Signed) John G. G. Camper M. D.

11-13 1929 (Address) 724 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11/14 1929
20 UNDERTAKER	ADDRESS
Samuel F Chandler & Co	Biddle

Important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50927

CERTIFICATE OF DEATH.

100-001 E 50927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Brown

(a) RESIDENCE No. 927 E Baltimore ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Brown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Askan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Frankel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Brown

(Address) 927 E Baltimore St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1929 to Nov 12 1929.

that I last saw her alive on Nov 12 1929,

and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos 9 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/24/29

Was there an autopsy? No

What test confirmed diagnosis? Hist Surg & Clinical Findings

(Signed) C Hyman M. D.

19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Retreat Israel

DATE OF BURIAL 11/13 19 29

20 UNDERTAKER Joseph Lewis

ADDRESS 1439 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

11/13 1929 C. HARRISON JONES, M.

Spec.—1-12-23—M&T—500 Blks.

E 50928

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001
10 E 50928

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew age Home 1-54 ST. WARD)

2-FULL NAME Solomon Kimmel

(a) RESIDENCE NO. Belvedere & Greenspring ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Becky Kleinman

6 DATE OF BIRTH (month, day, and year) Feb 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Abraham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1439 E. Baltimore St

15 Filed NOV 13 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/12 1929

17

I HEREBY CERTIFY, That I attended deceased from 11/4 . 1929 . to 11/11 . 1929 .

that I last saw him alive on 11/12 . 1929 .

and that death occurred, on the date stated above, at 10 a m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Meyer Miller M. D.

, 19 (Address) 3679 W. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herman Rest.	11/13 1929

20 UNDERTAKER Jack Levis 1439 E Balto St

ADDRESS

IMPORTANT is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 50929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159 of 2 E 50929

1-PLACE OF DEATH

City of Baltimore: (No. 1229 Hull St. St., 24-35 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Reta L. Cegelski.

(a) RESIDENCE NO. 1229 Hull St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 10, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Walter J. Cegelski.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Jersey City N.J.

12 MAIDEN NAME OF MOTHER Ella Bielinska.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Ella Cegelski. (mother)
(Address) 1229 Hull St.

15 Filed ....., 19.... .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Hennard, M. D.

11/12 1929 (Address) 1015 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	Nov 13 1929
20 UNDERTAKER George A. Weber	ADDRESS 705 S Ann

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

11 13 1929

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50930

CERTIFICATE OF DEATH

104-002 E 50930

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2805 Laurna Rd. Hosp. ST. 3321 Gelr. 55-65)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Gordon Buckey Jr.

(a) RESIDENCE NO. 2805 Laurna Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balt., Md.

PARENTS

10 NAME OF FATHER Chas. G. Buckey Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick, Md.

12 MAIDEN NAME OF MOTHER Mary Kellam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Waterloo N. C.

14 Informant Mrs. Chas. G. Buckey Jr.

(Address) 2805 Laurna Road, Balt.

15 Filed NOV 13 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1929, to Nov 12, 1929.

that I last saw him alive on Nov. 12, 1929

and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied tonsils and adenoids.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage, Shock, Post-Operative (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Undetermined.

Did an operation precede death? Yes; Date of Nov. 12, 1929

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edward A. Cooper, M. D.

Nov. 12 1929 (Address) 104 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemt	Nov 14 1929
20 UNDERTAKER	ADDRESS
Pentland & Co	1723 W Lafayette Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50931

E 50931

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Kennuch

(a) RESIDENCE NO. Preston + Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12 Dec 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Kennuch

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Bridget McIntyre

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston + Valley St

15 Filed NOV 15 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to Nov 12, 29, that I last saw h alive on Nov 11, 29 and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oldem. of Lungs

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Bernard Watts M. D.

11/13, 29 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Nov. 14 1929
20 UNDERTAKER	ADDRESS
Bila Wiedefeld	914 Greenmt Ave

Important: See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50932 · HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 291 Bernard ST.) (WARD)

2-FULL NAME Mary Shirley

(a) RESIDENCE No. 291 Bernard ST. (2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas Oliver Shirley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Merrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant: Mrs Mary Shirley

(Address) 291 Bernard St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 12, 1929, that I last saw h[illegible] alive on Nov 12, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage during birth

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Roscoe R Cross M.D.

11-12 1929 (Address) 2438 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: 11-13 1929

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

NOV 13 1929 C. HAMPSON JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50933 ~~50~~ 3

E 50933
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 713 Pierce St. 17-26 Ward)

2-FULL NAME Bernard West

(a) RESIDENCE NO. 713 Pierce St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 21 - 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	0	9	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John West

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Bertina Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Bertina West
(Address) 713 Pierce St

15 Filed ..... 19.... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 11 - 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

11/12. 1929 (Address) 713 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11-13 1929
20 UNDERTAKER Dennis Taylor	ADDRESS 816 Pa Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50934 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50934

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Williams

(a) RESIDENCE NO. 1048 Myrtle ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Moses Grice

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Della Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records
(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1929, to Nov. 11, 1929, that I last saw her alive on Nov. 11, 1929 and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Wes Thurnald, Jr. M. D.

11-11, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	11-13 1929
20 UNDERTAKER	ADDRESS
Lewis Eurton	Pine

Important. See instructions on back of certificates.

C. HAMILTON JOHNS, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50935 — HEALTH DEPARTMENT—CITY OF BALTIMORE — 90 E 50935

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1001 Bennett ST. 16th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chas. Dunn

(a) RESIDENCE NO. 1001 Bennett ST. Ala WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Mamie Dunn

6 DATE OF BIRTH (month, day, and year): Century

7 AGE — Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): — 070

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Jno. Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Duvall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mamie Dunn
(Address): 1001 Bennett Place

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M. D.
NOV 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 9/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1929, to Nov 9, 1929

that I last saw him alive on Nov 9, 1929

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Dis. Heart
Mitral Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) David E. Nagurney M. D.

11/12, 1929 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov 14, 1929
20 UNDERTAKER	ADDRESS 3221 Edmondson Ave
Mrs Katie R. Williams	

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 50936.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓ E 50936

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 638 George St. 17-24 Ward)

2-FULL NAME Andrew Cammuse

(a) RESIDENCE No. 638 George St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Cammuse

6 DATE OF BIRTH (month, day and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cement worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lancaster Co
(State or country) Va

PARENTS

10 NAME OF FATHER Fred Cammuse

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Millie Lankford

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Jennette Jackson
(Address) 1106 Stockton

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) Sudden ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? 638 George

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. C. Fuch, M. D.

(Address) 1001 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Co, Va	Nov 14, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 3A S Schroeder

OV 16 1929 HARRY JONES, M. D.

Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50937

CERTIFICATE OF DEATH

117 E 50937

REGISTERED NO.

1—PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1378 N. Carey ST. 15-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Naomi Valentine

(a) RESIDENCE NO. 1378 N. Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 26th 1918

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
11	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Buckingstown Md

PARENTS

10 NAME OF FATHER Rev L J Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Blanche Singleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Singleton Valentine
(Address) 1358 N Carey St

15 Filed 1-3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12-29

17 I HEREBY CERTIFY, That I attended deceased from 11-11-, 1929, to 11-12, 1929, that I last saw h alive on 11-12, 1929 and that death occurred, on the date stated above, at 2.50 p m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix
General Peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11 12 29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) C. L. Jackson M. D.

(Address) 600 N. Carey Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Nov 15th 1929

20 UNDERTAKER: Thomas E Wright — ADDRESS: 364 N Carey

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Evans

E 50938

HEALTH DEPARTMENT—CITY OF BALTIMORE

37-001 E 50938

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Purelove Evans

(a) RESIDENCE NO. 1429 E. St. Matthews ST.; WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Evans

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 27

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Ned McNeal

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary McNeal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed 11 3 1929 (s) HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1929, to Nov. 11, 1929, that I last saw her alive on Nov. 11, 1929 and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Thirnold Jr. M. D.

11-21 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Raleigh N. C.	11-13 1929
20 UNDERTAKER	ADDRESS
Byron Knight	1218 McElderry St

Important: See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 5093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 50939

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1014 N Baltimore ST. 18 WARD) 24

2—FULL NAME Katharine C Seim

(a) RESIDENCE NO. 1014 N Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Late John C Seim

6 DATE OF BIRTH (month, day, and year): Dec. 31 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11 10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry Repp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Son Albert Seim

(Address) 4403 Bellevue

15 Filed 1 3 1929 C. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 11- 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1929 to Nov. 11 1929.

that I last saw h alive on Nov 11 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

1 Myocarditis

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Enlarged Heart with dropsy

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? Yes.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

Nov 12 29 (Address) 612 N 40 st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Violetville Md

DATE OF BURIAL: 11-14 1929

20 UNDERTAKER: Wm Chas A J Rohde

ADDRESS: 2327 Edmondson ave

Spec.—1-10-21—M&T—1500 Blks.

E 50940 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50940

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH St. Joseph Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oliver Sts. ST. 9-18 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Boran

(a) RESIDENCE NO. 2019 Homewood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) 1927-4-6

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James J Boran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary E. Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary E Boran (Address) 2019 Homewood Ave

15 FILED 1 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12 1929

17

I HEREBY CERTIFY, That I attended deceased from 11-4, 1929, to 11-12, 1929, that I last saw h[illegible] alive on 11-12, 1929, and that death occurred, on the date stated above, at 3 10 a. m.

The CAUSE OF DEATH* was as follows:

Empyema - following a broncho-pneumonia.

CONTRIBUTORY (Secondary) 1st Left Lobar Pneumonia (duration) 1 day - Terminal broncho pneumonia (duration) yrs 1 mos 8-10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 11-5-29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. M. Clendenin, M. D.

(Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL Nov 14 1929

20 UNDERTAKER Mary M Redfield ADDRESS 501 E 22nd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 50941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 50941

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4017 Falls Road ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virgie Schaffer

(a) RESIDENCE NO. 4017 Falls Road ST., WARD New York City

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William I Schaffer

6 DATE OF BIRTH (month, day, and year) August 26 1888

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
41	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm I Schaffer

(Address) 4017 Falls Road

15 Filed 13 1929 C. HAMPSON JONES, M. D. Registrar

Mar NRM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1929, to November 14 1929, that I last saw h.. alive on November 10, 1929 and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Carcinoma of Uterus + Rectum

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Signs

(Signed) Frank H. Martin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Nov 14 1929
20 UNDERTAKER	ADDRESS
Ehrenwetter	[illegible]

Important. See instructions on back of certificates.

Spec.—1-29-29—L. F. S.—500 Bks.

E 50942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

71-002

E 50942

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2727 Riggs Ave. ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha M. Waltzinger

(a) RESIDENCE NO. 2727 Riggs Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of A. Fred. Waltzinger Jr.

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1895.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James M. Crawford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Lulu M. George

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant A. Fred Waltzinger Jr.
(Address) 2727 Riggs ave.

15 Filed NOV 13 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/13/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1929, to Nov 13, 1929, that I last saw h[illegible] alive on Nov 13, 1929 and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Meningitis F-H-P

(duration) 3 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Keall M. D.

11/17 1929 (Address) 47 W Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery.	Nov. 15, 1929,

20 UNDERTAKER Wm. E. Black ADDRESS 927 N. Broadway

Important. See instructions on back of certificates.

Spec.—6-19-15—M. & T.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50943 — E 50943

CERTIFICATE OF DEATH.

REGISTERED No. C 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 N. Charles St. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David L. Matthews

(Residence in Baltimore: No. 1402 Linden Ave, St.; 35-40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. September 27, 1850 (Month) (Day) (Year)

7-AGE. 79 yrs. 1 mos. 17 ds. If LESS than 1 day, 16 hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Salesman
(b) General nature of industry, business, or establishment in which employed (or employer). 66

9-BIRTHPLACE, (State or Country). Baltimore Co (Sparks)

PARENTS.

10-NAME OF FATHER. John D. Matthews

11-BIRTHPLACE OF FATHER (State or Country). Baltimore City

12-MAIDEN NAME OF MOTHER. Anna Foulke

13-BIRTHPLACE OF MOTHER (State or Country). Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Matthews

(Address) Sparks. Md

15-

Filed. 1 3 1929 C. HAMPSON JONES, M. D. Registrar. Per ACH

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 13 (Month) (Day) 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 9 1929, to Nov 1929, that I saw him alive on Nov 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: (

Gangrene in abdominal Cavity
Carcinoma
abscess (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. 0 mos. ds.

(Signed) P. S. Bourdeau-Sisson. M. D.

Nov. 1929 (Address) 1315 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 7 ds. In the State 35 yrs. mos. ds.

Where was disease contracted, if not at place of death? Auto, accident 2 yrs ago

Former or usual residence 1402 Linden Ave

19-PLACE OF BURIAL OR REMOVAL. Friends - Sparks - Md

DATE OF BURIAL. Nov 16 1929

20-UNDERTAKER Wm C. Burk - Son

ADDRESS Sparks, Md

important. See instructions on back of certificate.

...erty claimed. Exact statement of OCCUPATION is very ... may be properly

Spec.—1-12-28—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50944

CERTIFICATE OF DEATH.

90 ✓ E 50944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25-30 Francis St., 13-54 WARD)

2-FULL NAME Alice M Smith

(a) RESIDENCE NO. 25-30 Francis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	widow

5a If married, widowed, or divorced ~~HUSBAND~~ of or) WIFE of John A

6 DATE OF BIRTH (month, day, and year) May 30 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	73	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF ~~FATHER~~ Cornelius Dimmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Daisy DeHuff (Address) 25-30 Francis St.

15 Filed NOV 4 1929, 19 C. HAMPSON JONES, M.D. Registrar

Per E.T.S.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 5th, 1929, to Nov. 12th, 1929.

that I last saw her alive on Nov. 5th, 1929,

and that death occurred, on the date stated above, at 9-30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

1

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Elbert C. Reifert, M. D.

11/12 1929 (Address) 2274 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Hill -	Nov. 15 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr D Hoff 2020 N Charles St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50945

E 50945

CERTIFICATE OF DEATH

13 Ward 101-001

REGISTERED NO. 15-63

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3900 Garrison Blvd (ST.) (WARD)

2—FULL NAME William George Bunneche

(a) RESIDENCE NO. 3900 Garrison Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose C. Bunneche

6 DATE OF BIRTH (month, day, and year): Nov. 16. 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George J Bunneke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna M Cordes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs G Spichnagel

(Address) 1045 S Patterson Pk Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

DEC 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 13. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 19 29 to Nov 13 19 29

that I last saw him alive on Nov 13 19 29

and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary) Ac. Dil Heart.

(duration) yrs. mos. 5 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward H [illegible] M. D.

11/13 19 29 (Address) 2020 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 11/16 19 29

20 UNDERTAKER: D. W. Cook

ADDRESS: 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50946 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50946

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N Paca ST., 17-25 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Gardner

(a) RESIDENCE No. 408 N Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Albert Gardner

6 DATE OF BIRTH (month, day, and year) June 1st 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	5	12	11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 037

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer self — Baltimore

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albert Gardner (Address) 408 N Paca St

15 Filed NOV 14 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10 .19 9 . to Nov 12 .19 9 .

that I last saw her alive on Nov 11 .19 9

and that death occurred, on the date stated above, at 6:30 A m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) unknown

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) R. B. Kenyon, M. D.

11/12. 1929 (Address) 607 W. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 11/14 1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

NOV 14 1929

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Stilson 1091 N Fulton Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50947 89 E 50947

CERTIFICATE OF DEATH

REGISTERED NO. 16-22

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 923 N Fulton Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David May.

(a) RESIDENCE NO. 923 N Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate A May.

6 DATE OF BIRTH (month, day, and year): Sept 1850

7 AGE — Years: 79 — Months: 2 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Church

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Kate May

(Address) 923 N Fulton Ave

15 Filed ....., 19 ..... Registrar

NOV 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Nov. 12, 1929.

that I last saw h alive on Nov 12, 1929

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

angina Pectoris

2 hours -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J Thomas Fulton, M. D.

, 19 (Address) 1301 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexandria, Va — DATE OF BURIAL: Nov 15 1929

20 UNDERTAKER: W M Cook — ADDRESS: 1217 E Fond St

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50948

E 50948

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH University Hospital

City of BALTIMORE: (No. Balto. Md 4-30 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eva Petroshky

(a) RESIDENCE NO. 657 Portland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
43				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Lithuania

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lithuania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lithuania

14 Informant John Miller

(Address) 657 Portland St

15 Filed NOV 14 1929 C. HAMPSON JONES, M. D. Registrar

By EK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929 11-11-29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage 1 day

(duration) yrs. mos. ds.

(Signed) Eugene Kilby M. D.

(Coroner)

11/13, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lounden Pk. Date of Burial 11/14 1929

20 UNDERTAKER: Chas. B. Kuchanhas ADDRESS 631 S Paca

(Not to be filled in except when directed by the Registrar. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50949

CERTIFICATE OF DEATH.

90 E 50949

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1508 Clestmore St. 12 59 Ward

2-FULL NAME Wilbur H. Evans

(a) RESIDENCE NO. 1508 Clifton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, ~~Married~~, Widowed, or ~~divorced~~, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Fannie R. Evans

6 DATE OF BIRTH (month, day, and year): Mar. 17-1859

7 AGE: Years 70 Months 7 Days 25 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Street Cleaning Dept

(c) Name of employer: City of Balto.

9 BIRTHPLACE (city or town)

(State or country): Penna

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa

14 Informant: George B. Evans

(Address): 1508 Clifton St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

11/13 1929 Address 3632 Rolandmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Conn Date of Burial Nov. 14 1929

20 UNDERTAKER: Harry W. Ehlen ADDRESS 18 E. North

Now should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 14 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50950

E 50950

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ST. 13-5K WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie Middleton

(a) RESIDENCE NO. 3419 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. Middleton.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address) Baltimore City Hospitals.

15 Filed NOV 14 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1929, to Nov 13, 1929.

that I last saw her alive on Nov 13, 1929

and that death occurred, on the date stated above, at 10:00 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Adhesive

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General am. lab.

(Signed) Fred M. Dorsey, M. D.

, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley Chapel Rock Hall Md	Nov 15 1929
20 UNDERTAKER Franklin W Seitz	ADDRESS 1074 W 33 St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50951 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50951

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital (ST.) (WARD) REGISTERED NO. 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Annie Black

(a) RESIDENCE NO. 1502 Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 4 mos. 17 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George R. Black

6 DATE OF BIRTH (month, day, and year) June 27, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Collins

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine James

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mr. George R. Black

(Address) 1500 Webster St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/13/29

17

I HEREBY CERTIFY, That I attended deceased from 10/12, 1929, to 11/13, 1929, that I last saw her alive on 11/13, 1929, and that death occurred, on the date stated above, at 8:50 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis (duration) ? yrs. ? mos. dd.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 10/14

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Thos. E. Stacy Jr. M. D.

11/13, 1929 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Nov 16, 1929

20 UNDERTAKER Harry N. Witzke ADDRESS 1531 N. Lombard St

important. See instructions on back of certificate.

OV 14 1929 C. HERBERT JONES, Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50952

CERTIFICATE OF DEATH

160 ✓ E 50952

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST., 7-A WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Maloney

(a) RESIDENCE NO. 2011 Gough ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	

5a If married, widowed, or divorced
RUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 20-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1 ~~9 mos~~	24 ~~11~~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael J. Maloney

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ruth L. Brown

13 BIRTHPLACE OF MOTHER (city or town) Balto - Md
(State or country)

14 Informant Michael J. Maloney
(Address) 2011 Gough St.

15 Filed NOV 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13 '29

17 I HEREBY CERTIFY, That I attended deceased from 11-5, 1929, to 11-13, 1929.

that I last saw him alive on 11-13, 1929

and that death occurred, on the date stated above, at 10 25 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

7 mos. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko M. D.

(Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holylewood Harford Road	Nov 14 1929
20 UNDERTAKER J. A. McGann	ADDRESS 3000 E. Balto. St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50953

E 50953

CERTIFICATE OF DEATH

REGISTERED NO. 99 0 2 E 50953

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2437 Callow St. 13-59 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophie Spalding Samuels

(a) RESIDENCE NO. 2437 Callow St., Rear WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newberry S.C.

PARENTS

10 NAME OF FATHER Harry H. Samuels

11 BIRTHPLACE OF FATHER (city or town) (State or country) London, Eng.

12 MAIDEN NAME OF MOTHER Annie Foote

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Mrs. Norwood

(Address) Howard Pk.

15 Filed NOV 14 1929, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from December, 1926, to Nov. 13, 1929

that I last saw her alive on June 15, 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chron. Bronchitis
Bronchial Asthma
Acute Coronary Thrombosis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Failure Partially one hour

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Allen Twooman M. D.

. 19 (Address) 2340 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	11/15/1929.
20 UNDERTAKER	ADDRESS
Harry Sondheim	115-20 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50954 — CERTIFICATE OF DEATH. — 117 E 50954

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St.) (4-46 WARD)

2-FULL NAME ~~Dan~~ William Adkinson

(a) RESIDENCE NO. 716 Bartlett Ave St. WARD Aberdeen Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly Adkinson

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Adkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Tarbutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Lilly Adkinson

(Address) 716 Bartlett ave

Filed NOV 14 1929 Per HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-5, 1929, to 11-13, 1929.

that I last saw him alive on 11-13, 1929

and that death occurred, on the date stated above, at 2 35 P m

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 1/4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 11-5-29

Was there an autopsy? no

What test confirmed diagnosis? Operation & Section of Appendix

(Signed) Ernest Spencer Jr. M. D.

, 19 (Address) St. Agnes Hosp Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Md.

DATE OF BURIAL Nov. 16 1929

20 UNDERTAKER Wm. J. Tickner & Sons

ADDRESS Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50955

CERTIFICATE OF DEATH

90 ✓ E 50955

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2024 N. Fulton Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antonia M. Ross.

(a) RESIDENCE NO. 2024 N. Fulton Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hutzler Bros.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER August F. Werner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederica Streitberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Helen C. Rodgers

(Address) 2024 N. Fulton Ave.

15 Filed NOV 14 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1929

17 I HEREBY CERTIFY, That I attended deceased from 10/1, 1929, to 11-12, 1929, that I last saw h[illegible] alive on 11-12, 1929 and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Anemia (Pernicious)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 3 yrs prior Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) [illegible] M. D.

, 19 (Address) 1928 N. Eutaw Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Nov. 1929
20 UNDERTAKER	ADDRESS
Wm. J. Hecker Sons	Norfolk Va

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 50956

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1700 Eutaw Place (ST.) 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marshall Clinton Dunn

(a) RESIDENCE NO. 1700 Eutaw Place ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 7 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret F. Dunn

6 DATE OF BIRTH (month, day, and year) Apr. 2, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Relief Dept.

(b) General nature of industry, business, or establishment in which employed (or employer): P. R. R.

(c) Name of employer: Retired.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Michael Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md.

12 MAIDEN NAME OF MOTHER: Susan V. Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Margaret F. Dunn

(Address) 1700 Eutaw Place

Filed NOV 14 1929 HAMILTON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1929

17 I HEREBY CERTIFY, That I attended deceased from October 14, 1929 to Nov 12, 1929 that I last saw h[illegible] alive on Nov 12, 1929 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. D. Zubel M. D.

19 (Address) 757 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Nov. 15, 29
20 UNDERTAKER: W. M. Tickner & Sons	ADDRESS: North & Pa

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Seldner 4905 Belair Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50957

CERTIFICATE OF DEATH

91-002
E 50957

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 Gilmore ST. 10-14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles I. Phillips

(a) RESIDENCE NO. 1012 Gilmore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane E. Phillips

6 DATE OF BIRTH (month, day, and year) Aug. 8. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edwin Phillips

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Glenn

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Roy Phillips
(Address) 1012 Gilmore St.

15 Filed NOV 14 1929, 19 C. HAMPTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 30 1929, to Nov 13 1929, that I last saw h[illegible] alive on Nov 10 1929, and that death occurred, on the date stated above, at 215 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senile Degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) Geo Peters M. D.

Nov 14 1929 Address 4700 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	11/16 1929
20 UNDERTAKER Wm. Cook	ADDRESS 1219 N. Fulton Ave

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 50958

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary REGISTERED NO. 47

CITY OF BALTIMORE: (No. 2069 ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Cunningham

(a) RESIDENCE No. 2532 W. Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Geo B Cunningham

6 DATE OF BIRTH (month, day, and year): 2/5/66

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Schieber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mt Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mt Known

14 Informant: G Herbert Cunningham

(Address): 2532 W Fayette St

15 Filed NOV 14 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/13 19 29

17 I HEREBY CERTIFY, That I attended deceased from 10/1/, 19 29, to 11/13, 19 29,

that I last saw h alive on 11/13, 19 29,

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes. Date of 10/8/29

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) James L. Cumming Jr. M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Nov 16 1929

20 UNDERTAKER: W M Rouleau

ADDRESS 223 5th

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50959

CERTIFICATE OF DEATH

101-001 E 50959

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 1400 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Roosevelt Trower

(a) RESIDENCE NO. 2000 Druid Hill Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Fred Trower

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Allie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1929, to Nov. 12, 1929

that I last saw him alive on Nov. 12, 1929

and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam. P.C.

(Signed) Warren H. McLean M. D.

11-12, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Townsend Va	Nov 14, 1929
20 UNDERTAKER Jesse H. Redden	ADDRESS 436 N. Biddle St

IF DEATH IS TO BE CREMATED, SPECIAL PERMIT REQUIRED. 1 4 1929 C. HAMILTON JONES, M. D. PMC

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—206 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50960

CERTIFICATE OF DEATH.

129

E 50960

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3036. Abell Ave. St. 12-50 Ward)

2-FULL NAME Margaret D Buschman

(a) RESIDENCE NO. 3036. Abell Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. H. Buschman

6 DATE OF BIRTH (month, day, and year) Nov. 10-1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	—	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Fred. Meurer

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Doris Finke

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany.

14 Informant Dorothy Buschman

(Address) 3036 Abell Ave

15 Filed NOV 14 1929 C. HAMPSON JONES, M. D. Registrar

By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13th 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5 1929, to Nov. 13 - 1929, that I last saw h[illegible] alive on Nov. 13 - 1929 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows: Interstitial nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Wass. laboratory

(Signed) C. Hampson Jones M. D.

, 19 (Address) 817 Park Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Nov 15 1929

20 UNDERTAKER Francis A. Fink ADDRESS 915 W. Fay

dition should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If LESS than a day, hours or minutes must be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50961

CERTIFICATE OF DEATH

24-001 E 50961

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 E. Eager ST. 10-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elisa Koch

(a) RESIDENCE NO. 1415 E Eager ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Koch

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eisenach Germany

PARENTS

10 NAME OF FATHER Christian Bendel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eisenach Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eisenach Germany

14 Informant Mrs. John Koch

(Address) 1415 E Eager

15 Filed NOV 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 12. 29.

17 I HEREBY CERTIFY, That I attended deceased from November 7 19 29 to November 12 19 29

that I last saw h alive on November 12 19 29

and that death occurred, on the date stated above, at 10-10 P. m.

The CAUSE OF DEATH was as follows:

1 Apoplexy Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hattie K. A. McEy M. D.

11/13, 1929 (Address) 1034 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Nov 15 1929.
20 UNDERTAKER	ADDRESS
L. Neumann	32 S. Broadway

OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 50962

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50962

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 N. Streeper St. 16-22 WARD)

2-FULL NAME Zachariah Fields

(a) RESIDENCE NO. 1114 N. Streeper ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Ship

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middlesex Co Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Eliza Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middlesex Co Virginia

14 Informant (Address) Robert Fields 1114 N. Streeper St

15 Filed NOV 14 1928 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11 1929

17

I HEREBY CERTIFY, That I attended deceased from 10/27. 1929. to 11/10. 1929.

that I last saw h[illegible]alive on 11/10 1929.

and that death occurred, on the date stated above, at 2-40 p. m.

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions.

(duration) yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & High Contention (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hypertension + Uraemia

(Signed) David Saunders, M. D.

(Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 11/14 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pleasant St

MEDICAL CERTIFICATE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50963

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50963

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 8-40 ST., WARD)

2—FULL NAME Nelson Marshall Schwaner

(a) RESIDENCE NO. ~~3106~~ 3106 Maisel Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 10 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 19, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Nelson Marshall Schwaner

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Heller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Nelson Marshall Schwaner

(Address) 3106 Maisel Ave.

15 Filed NOV 14 1929 C. HAMPSON JONES, Registrar

By B. Reed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from November 11, 1929, to November 12, 1929, that I last saw him alive on November 12, 1929 and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Choked disc Convulsions

(Signed) Richard T. Shackelford, M. D.

Nov. 13. 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Nov 14 1929
UNDERTAKER Philip Sterling	ADDRESS 2016 Orleans St.

Property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50964 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 50964

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2828 E. Madison St. ST. 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine Fuchs

(a) RESIDENCE NO. 2828 E. Madison St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. A. Fuchs

6 DATE OF BIRTH (month, day, and year) Aug. 16/1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Gerhold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara-------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Geo. A. Fuchs

(Address) 2828 E. Madison St.

15 Filed NOV 14 1929, 19 C. HAMPSON JONES, Registrar

Per Philip Henry

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11/29

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1929, to Nov 11, 1929, that I last saw her alive on Nov 11, 1929 and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Uraemia — 3 days

cardio-vascular-renal — 5 years.

Chr. Bronchitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arthritis - sclerosis - arthritis — (Hypertension) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam of urine - Blood pressure

(Signed) Louis F. Krumeich, M. D.

, 19 (Address) 222 N. Kenwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mathews Cem.

Undertaker

DATE OF BURIAL Nov. 14 1929

ADDRESS 2016 Orleans St.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50965

CERTIFICATE OF DEATH

90 E 50965

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 666 W. Fayette St. 425 Ward)

2-FULL NAME Bernard E. Lee

(a) RESIDENCE NO. 666 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Florence Lee

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	72			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Commission Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto - Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Catherine Loggins
(Address) 3400 Lyndale Ave

15 Filed NOV 14 1929 H. Harrison Jones Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 — 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fillet M. D.

11/13 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Nov 15 1929
20 UNDERTAKER	ADDRESS
F. A. Wanseverson	703 S. Ha...

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should be sure CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

50966

90

E 50966

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 S Scott ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Porbaugh

(a) RESIDENCE NO. 508 S. Scott ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Elias Porbaugh

6 DATE OF BIRTH (month, day, and year) Aug 15-1863

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
66	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 027

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shanksville Pa

PARENTS

10 NAME OF FATHER John Weigle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Reiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs Nellie Schaffer

(Address) 508 S. Scott St.

15 Filed ..., 19 ... Registrar

HAMPSON JONES, M. D.

OV 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from August, 1929, to Nov 13, 1929 that I last saw h.er alive on Oct 2, 1929 and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis - apoplexy

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hubert R. M. D.

11/14 1929 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Walker Cem Shanksville Pa	Nov 14 1929

20 UNDERTAKER	ADDRESS
Jno C. Miller & Son	2334 Jefferson St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 50967 90 E 50967

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1446 N. Mount St. 15-21 WARD)

2-FULL NAME Henry Dotson

(a) RESIDENCE NO. 1446 N. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Armstead Dotson

6 DATE OF BIRTH (month, day, and year) 9-2-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

PARENTS

10 NAME OF FATHER Bates Dotson

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Marys Co. Md.

12 MAIDEN NAME OF MOTHER Rebecca Spears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys Co. Md.

14 Informant Katie Dotson, wife (Address) 1446 N. Mount St.

15 Filed NOV 14 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11- 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-10- 1929, to 11-11- 1929, that I last saw him alive on 11-11- 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease

History Personal (duration) yrs mos 6 days 3 days

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jno. C. Ruge, M. D.

, 19 (Address) 1516 N. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Nov 15 1929
UNDERTAKER	ADDRESS
Joseph A. Lively	409 N. Monroe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

W. 10033

E 50968 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50968.

89

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 1615 Warwick ave ST. 5-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob S. Sacks

(a) RESIDENCE NO. 1615 Warwick ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Yetta

6 DATE OF BIRTH (month, day, and year) June 10, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Sacks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel Hoeck

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Yetta Sacks

(Address) 1615 Warwick ave

15 Filed 11/14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14/29.

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1929; to Nov 4, 1929, that I last saw him alive on Nov 7, 1929, and that death occurred, on the date stated above, at 8 9 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? electrocardiogram

(Signed) [signature], M. D.

11/14 1929 (Address) 1810 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL Nov 14 1929

20 UNDERTAKER Sol Lippman & Bro

ADDRESS 1129 E Balto St.

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. In order that it may be properly classified. All blanks should be carefully supplied. Any information desired in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50969 ✓ 90 E 50969

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rena Davis

(a) RESIDENCE NO. 217 Spring ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Madas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha Madas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of
(Address) Balto. City Hospitals UNIV

15 Filed 4 1929 C. HAMPSON JONES, M. D. Registrar
4061

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1929 to Nov. 9, 1929, that I last saw her alive on Nov. 9, 1929 and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows: Myocarditis, chronic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McKean, M. D.

11-12, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health. — ADDRESS NOV 14 1929

For Wm. F. Woodall

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50970

CERTIFICATE OF DEATH

129 / E 50970

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 321 E. 24th St. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Henze

(a) RESIDENCE NO. 321 E. 24th. St., ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 3 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Julia Burns Henze

6 DATE OF BIRTH (month, day, and year) July 30, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimre, Md.

PARENTS

10 NAME OF FATHER Agustus Henze

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. G. C. Ross
(Address) 321 E. 24th. St.

15 Filed NOV 15 1929 G. HAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11 19 29 to Nov. 12 19 29

that I last saw h alive on Nov. 12 19 29

and that death occurred, on the date stated above, at 3.40 P. M.

The CAUSE OF DEATH* was as follows:

Ch Nephritis

(duration) yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) C. F. Ellyson M. D.

11/13 19 29 (Address) 370 Ridgely Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	11/15/1929
UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor. 10-10-29—A Co.—100 Bks.

E 50971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

180-001 E 50971

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1020 E. Fayette St., 5-8 Ward)

2-FULL NAME Helen Sneed

(a) RESIDENCE NO. 1020 E. Fayette St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., If of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 15-1929

7 AGE: Years — | Months 1 | Days 28 25 | IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Henry Sneed

11 BIRTHPLACE OF FATHER (city or town) N.C.
(State or country)

12 MAIDEN NAME OF MOTHER L. Mitchell

13 BIRTHPLACE OF MOTHER (city or town) A.A. Co.
(State or country)

14 Informant Henry Sneed
(Address) 1020 E Fayette

15 Filed NOV 15 1929 19__ C. HAMPSON JONES M. D. Registrar

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13. 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Jury~~ (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia - Burns 4 year old accidentally caused by infant ~~Brother~~ Mother cutting off air.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) Sudden

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? ns

Did an operation preeede death? ns Date of _____

Was there an autopsy? ns

What test confirmed diagnosis? _____

(Signed) W. T. Kelly, M. D.

Nov 14, 1929 (Address) 1629 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary — DATE OF BURIAL 11.14 1929

20 UNDERTAKER: Mr R A Elliott — ADDRESS 1225 Argyle

R—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 2-29-28—L. F. S.—500 Blks.

E 50972

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50972

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 534 N. Milton Ave ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora E. Maasch

(a) RESIDENCE NO. 534 N. Milton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2/86

7 AGE: Years 43 | Months 5 | Days 8 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ernest W. Maasch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Elizabeth Jahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Ernest W. Maasch

(Address) 534 N. Milton Ave

15 Filed ..... 19 ..... Registrar

C. HEDLEY JONES, M. D.

NOV 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 19 29, to Nov 13, 19 29

that I last saw h alive on Nov 13 19 29

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.
Chr. Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
Pulmonary Edema 7 mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Usual

(Signed) Wm. G. Geyer M. D.

19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Com.

DATE OF BURIAL: Nov 16 19 29

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 50973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 50973

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1205 E. Madison St 10-14 Ward)

2-FULL NAME Alexander Stewart

(a) RESIDENCE NO. 1205 E. Madison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Alexander Stewart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Annie Rose
(Address) 533 N. Caroline St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Pneumonia (Lobar)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Mallen, M. D.

11/15/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — DATE OF BURIAL Nov 14 1929

20 UNDERTAKER Wm. R. A. Elliott — ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50974

CERTIFICATE OF DEATH.

E 50974

REGISTERED NO. 67 29

1-PLACE OF DEATH

CITY OF BALTIMORE: No 926 Poplar Grove St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan H Caspar

(a) RESIDENCE NO. 926 Poplar Grove ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 2 yrs mos ds How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Caspar.

6 DATE OF BIRTH (month, day, and year) Aug 10 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	3	0	

Aug 10th

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria.

14 Informant (Address) John A Caspar.

15 Filed NOV 15 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 11 1929 to Nov 14 1929 that I last saw h[illegible] alive on Nov 14 1929 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis.

(duration) 5 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dr. Mitchell, M. D.

Nov 14 1929 (Address) 290 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Catholic Cemetery	11-16 1929
20 UNDERTAKER	ADDRESS
H C Branning & Son	1136 Pulaski Hwy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50975

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

E 50975

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Millinar ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mellon Jackson

(a) RESIDENCE NO. 1605 Millinar ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Ben Patterson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER Mary Jackson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Leroy Jackson

(Address) 1424 Hamplead alley

15 Filed NOV 15 1929, 19... H. WILSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 13, 1929, that I last saw him alive on Nov 13 1929 and that death occurred, on the date stated above, at 9-45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) J. Edward Fisher, M. D.

Nov 14 19 29 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Nov 16 1929
20 UNDERTAKER John W Henderson	ADDRESS 1503 E Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Mary Wright

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50976

CERTIFICATE OF DEATH

1948 E 50976

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wright

(a) RESIDENCE NO. 1142 McElderry St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jim Wright

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Sumter
(State or country) S.C.

PARENTS

10 NAME OF FATHER Morris Young

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S.C.

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S.C.

14 Informant Ada Gary
(Address) 1143 McElderry St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

By ..... Deputy Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Hemorrhage due to stab wounds neck and arms.

Homicide (Own)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jos H Evans, M. D.

11/14/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 11-15 1929

20 UNDERTAKER Byrnes & Eagles 1218 McElderry St

ADDRESS

OV 15 1929

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50977

E 50977

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St. 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G. Kelley

(a) RESIDENCE NO. Bengies, Md. Long Beach WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Ewing Kelley

6 DATE OF BIRTH (month, day, and year) April 7- 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired 10 years

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas L. Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Bunnig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Herbert D. Kelley

(Address) 522 E. 25th St.

15 Filed NOV 15 1929 C. HAMPTON MOORE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 3, 1929, to Nov. 12, 1929.

that I last saw him alive on Nov 12, 1929.

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis

Pneumonia (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem

(Signed) V. Messina, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	Nov. 15 1929
20 UNDERTAKER Horace H. Burgee	ADDRESS 3631 Gelston Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50978

E 50978

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 9-47 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. N. Carroll Grimmel

(a) RESIDENCE No. 515 Chestnut Hill Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 23-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	23	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Factory Work do
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Maryland Cork Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Nicholas G. Grimmel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie V. Collier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Nicholas Grimmel
(Address) 515 Chestnut Hill ave

15 Filed NOV 15 1929 C. HAMPSON JONES, M. D. Registrar
For L.N.L.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-10 1929, to 11-14 1929
that I last saw him alive on 11-14 1929
and that death occurred, on the date stated above, at 9.30 a.m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) George Brenner M. D.
, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natnre of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Nov. 16 1929.

20 UNDERTAKER ADDRESS
Horace H. Burgee 2431 Frederick Rd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50979

CERTIFICATE OF DEATH

90 E 50979

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 335 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Saaserin

(a) RESIDENCE NO. 1030 Grundy ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-29

17 I HEREBY CERTIFY, That I attended deceased from 11-12, 1929, to 11-14, 1929.

that I last saw him alive on 11-14, 1929

and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Parenchymatous

over 1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

over 1 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. P.C. Lab. X-ray

(Signed) Harris M. McLean, M. D.

11-15, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Int. Soc.	11/15 1929
20 UNDERTAKER	ADDRESS
Joch Levis	1439 E Balt St

OCT 15 1929 C. HAMPSON JOHNS, M.D.

Before signing be careful to see that all items are properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50980

CERTIFICATE OF DEATH

24 ✓ E 50980

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Naomi Baggett

(a) RESIDENCE NO. 3614 Elm Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28, 1917

7 AGE — Years: 12 — Months: 1 — Days: 17 (16) — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): School —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ellicester Md

PARENTS

10 NAME OF FATHER: John H. Baggett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Clara Gobelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Granite Md

14 Informant: John H. Baggett

(Address) 3614 Elm Ave

15 Filed NOV 15 1929, 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929 to Nov 14, 1929.

that I last saw h alive on Nov 14, 1929

and that death occurred, on the date stated above, at 2.45 p m.

The CAUSE OF DEATH* was as follows:

Meningitis (Meningococcic)

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary): None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 3614 Elm Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings + Spinal puncture

(Signed) Addison Craft Libby, M. D.

11-14, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Saint Mary's Hm Cem — DATE OF BURIAL: Nov 15 1929

20 UNDERTAKER: Chamberlain & Son — ADDRESS: 345 Eastern Ave

IMPORTANT—Before writing, read carefully directions printed on back hereof. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12 9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50981

CERTIFICATE OF DEATH.

129 E 50981

1-PLACE OF DEATH

City of BALTIMORE: (No. 309 S. Parrish St. 11-28 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Winkler

(a) RESIDENCE NO. 309 S. Parrish St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter H Winkler

6 DATE OF BIRTH (month, day, and year): October 25-1894

7 AGE — Years: 35 — Months: — — Days: 20 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Va

(State or country)

PARENTS

10 NAME OF FATHER: Samuel C. Cooper

11 BIRTHPLACE OF FATHER (city or town): W. Va

(State or country)

12 MAIDEN NAME OF MOTHER: Ida May Mundy

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country)

14 Informant: Walter H. Winkler

(Address) 309 S. Parrish St.

Filed NOV 15 1929 E. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): November 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-20-29 to 11-14-29, that I last saw h[illegible] alive on 11-14-29, and that death occurred, on the date stated above, at 9 9 m.

The CAUSE OF DEATH was as follows:

Nephritis

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) yrs. mos. 2 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Dunn M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Nov. 18 1929

20 UNDERTAKER: George L. Schmidt ADDRESS: 2101 Eutaw Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50982

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 E 50982

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. Harry Koenig ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Koenig

(a) RESIDENCE NO. 1336 N Washington St 919 Granby ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth ? yrs. ? mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 1895 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	2 4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Alec Koenig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hattie Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed NOV 15 1929, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 19 29, to Nov. 13, 19 29, that I last saw him alive on Nov. 13, 1929 and that death occurred, on the date stated above, at 7:50 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonitis Lauricus, Pneumonia (undetermined)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Decubitus Ulcer, Sacrum (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Histo. Exam. Autopsy

(Signed) Warren H. McIlvain, M. D.

11-13, 19 29 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	Nov 16 1929
20 UNDERTAKER	ADDRESS
M. J. C. Dypolla	3? Lamb

IMPORTANT—Answer all questions fully and properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 7-17-26—A Co.—200 Bks.

E 50983

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50983

40

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1321 N. Carey St. 15-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gray

(a) RESIDENCE NO. 1321 N. Carey St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Basil Gray

6 DATE OF BIRTH (month, day, and year) April 9, 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	62	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co

(State or country) Md

PARENTS

10 NAME OF FATHER Charles Golden

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Basil Gray

(Address) 1321 N. Carey St.

15 Filed NOV 15 1929 C. HAMPSON JONES M. D. Registrar

Per Hall

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

11-12-29

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 c 19 29 to Nov 12 19 29

that I last saw h.. alive on Nov. 12 19 29

and that death occurred, on the date stated above, at 10:45 A.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Specific Rheumatism

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto., Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm R Boston M. D.

19 (Address) 1512 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Zion Cemetery	Nov 15, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 822 Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50984

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50984

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 90

CITY OF BALTIMORE: (No. 17-24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Diggs

(a) RESIDENCE NO. 559 Oxford ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address): Baltimore City Hosp.

Filed NOV 15 1929 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 19 28 to Nov. 12, 19 29

that I last saw her alive on Nov. 12, 19 29

and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Interstitial

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist & C

(Signed) Warren W. McCann, M. D.

11-12, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Nov. 15, 1929
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	322 N. Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50985

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50985

46

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1332 W North Ave ST., 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Maith

(a) RESIDENCE NO. 1322 N North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) dry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John L Maith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Eliza Sands

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Raymond Maith

(Address) 1322 N North Ave

15 Filed NOV 15 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-13-29

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1929, to Nov 13, 1929, that I last saw her alive on Nov 8 1929 and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma Uterus.

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of August 1928

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E E Buxton, M. D.

11 15, 1929 (Address) 301 East Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk Crem	11-16, 1929
UNDERTAKER E & S Harle	ADDRESS 115 E West St

IMPORTANT: Answer all questions carefully, supplied. NOTE: Cause of death must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 50986

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hdq Westsp 16-67 ST. WARD)

2-FULL NAME James L. Shipley

(a) RESIDENCE NO. 3044 Annah ST., Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Cauc	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 11, 1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John S. Shipley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co., Md.

12 MAIDEN NAME OF MOTHER Louisa M. Lowthey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Report
(Address)

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1929, to Nov 13, 1929.

that I last saw him alive on Nov. 13, 1929.

and that death occurred, on the date stated above, at 9-50 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 2 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) C. Hampson Jones, M. D.

11/13/29 19 (Address) Union Mem Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Nov. 16 1929

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 West Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should name CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50937

CERTIFICATE OF DEATH

129 ✓ E 50937

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1004 Hollins ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Manning

(a) RESIDENCE NO. 1004 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Bernard Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mamie Sullivan

(Address) 1004 Hollins St.

15 Filed NOV 15 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1. 19 29. to Nov 13. 19 29.

that I last saw her alive on Nov. 13. 19 29

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Hypertension.)

(duration) yrs. mos. 15 Hrs.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Urine Analysis &c.

(Signed) Thos. Norton, M. D.

11/14, 19 29 (Address) 888 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Nov. 16 19 29
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 West Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50988
231085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 50938
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Kirby

(a) RESIDENCE NO. 1648 Forsuch Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 12-27-'50

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	10	13 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 10 Fish Market

(b) General nature of industry, business, or establishment in which employed (or employer) 18

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Luther Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Vann Kirk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 5 1929, 19 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1929, to Nov 14, 1929, that I last saw h[illegible] alive on Nov 14, 1929 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis - myocardial

Insufficiency (duration) 5 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) Hedwig Kaercy, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gordon Park Cemetery	Nov. 18 1929
20 UNDERTAKER	ADDRESS
Henry Sander & Sons Inc	Baltimore St. & Broadway

NOTE—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50989

CERTIFICATE OF DEATH

29 E 50989

28831

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ada K. Grove.

(a) RESIDENCE NO. 106 N. Burnett St. St., 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed or divorced~~ (or) WIFE of Leslie Grove.

6 DATE OF BIRTH (month, day, and year) — — 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	25	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge Md.
(State or country)

PARENTS

10 NAME OF FATHER William J. Bestpitch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Wilson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Leslie Grove. (husband)
(Address) 106 N. Burnett St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 18 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus.

Self induced Abortion.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 106 N. Burnett St.

Did an operation precede death? Yes Date of Nov. 11, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto F. Einhardt, M. D.

11/14 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 11/16 1929

20 UNDERTAKER J. F. Lahey & Son — ADDRESS 1318 E. Pr. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 15 1929

Per B&M

Spec.—1-10-21—M&T—1500 Bks.

E 50990 HEALTH DEPARTMENT—CITY OF BALTIMORE E 50990

CERTIFICATE OF DEATH. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital S. 6-11 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina J. Thalheimer

(a) RESIDENCE NO. 29 W. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Thalheimer

6 DATE OF BIRTH (month, day, and year) Oct. 24-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Kuhlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) John A. Thalheimer 29 W. Preston St.

15 Filed NOV 15 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14/29 19

17

I HEREBY CERTIFY, That I attended deceased from 11/12/29, 19, to 11/14/29, 19, that I last saw her alive on 11/13/29, 19, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

carcinoma of liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 12 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/13/29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. Hunderich M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 11/16 19 29

UNDERTAKER Chas. J. Frank & Son ADDRESS 1181 N. Howard

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

162 E 50991

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Ward

(a) RESIDENCE NO. Same ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	15 min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Conway Ward

11 BIRTHPLACE OF FATHER (city or town) Tuskaloosa (State or country) Alabama

12 MAIDEN NAME OF MOTHER Lena Barnes Tisdale

13 BIRTHPLACE OF MOTHER (city or town) Mc Williams (State or country) Alabama

14 Informant Mrs. Lena Ward

(Address) 1647 Williams ave

15 Filed NOV 5 1929, 19 C. HAMPSON JONES, M. D. Registrar

3994

4064

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11, 19 29, to Nov. 12, 19 29, that I last saw h[illegible] alive on Nov. 12, 19 29 and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia
Neonatorum

(duration) yrs. mos. 3 hrs.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs mos 3 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James H. Phillips, M. D.

, 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	Nov 14 1929
20 UNDERTAKER [illegible] Health.	ADDRESS

Be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50992 ✓ 129 E 50992

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 3-d WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Steven Kirby

(a) RESIDENCE NO. 408 S. Caroline ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Barlow Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Catherine Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Record.

(Address)

15 Filed ..... 19 ..... Registrar

4065

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11/11/29

17 I HEREBY CERTIFY, That I attended deceased from 10/28, 1929 to 11-11, 1929, that I last saw him alive on 11-11, 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy
Prostate. Cystitis.

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Chronic nephritis
exacerbation (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

11-11, 1929 (Address) Balto. City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

NOV 15 1929

NOV 15 1929 C. HAMPSON JONES, M. D.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 185 E 50993

1—PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lafayette and John ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Blakeley

(a) RESIDENCE NO. 5361 Virginia Avenue, Towson, Md.
(Usual place of abode) WARD

Length of residence in city or town where death occurred yrs. 3 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Blakeley

6 DATE OF BIRTH (month, day, and year) January 5, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	10	10	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County Md
(State or country)

PARENTS

10 NAME OF FATHER Isaac Frazier

11 BIRTHPLACE OF FATHER (city or town) Baltimore County
(State or country)

12 MAIDEN NAME OF MOTHER Maria Proctor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore County
(State or country)

14 Informant Frazier Mabel Parker (Hamilton)

(Address) 731 Virginia Avenue Towson Md

15 Filed NOV 5 1929, 19 C. HAMPSON JONES, M. D.

By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15/29

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1929, to November 15, 1929, that I last saw her alive on November 15, 1929, and that death occurred, on the date stated above, at [illegible] P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Fracture left femur

(duration) yrs. 2 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Earle P. Clemson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. M. E. Cem.

DATE OF BURIAL Nov 18 1929

20 UNDERTAKER Joseph Burns Sons

ADDRESS Towson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50993

CERTIFICATE OF DEATH

24-001 E 50993

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1907 Barclay st ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Steinkamp

(a) RESIDENCE NO. 1907 Barclay st ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Henry J. Steinkamp

6 DATE OF BIRTH (month, day, and year) 6-4-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Nicholas Kaiser

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Wottmeyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant H. Steinkamp
(Address) 1907 Barclay St

15 Filed NOV 15 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 10th, 19 29, to Nov 13, 19 29

that I last saw h alive on Nov 13, 19 29

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia (right side)
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Heart failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald D. Jones, M. D.

, 19 (Address) 414 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Nov 16 1929
20 UNDERTAKER	ADDRESS
Mary M Wedefield	501 E 22nd St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50995

CERTIFICATE OF DEATH

90 E 50995

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 E 21 st. ST. 9-4th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Estelle L Blaney

(a) RESIDENCE NO. 520 E 21 st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced (or) WIFE of John F. Blaney.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER J. Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John Blaney

(Address) 520 E. 21 st St

15 Filed NOV 15 1929 16 H. Hanson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14-1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 14, 1929, to Nov 14, 1929, that I last saw h[illegible] alive on Nov 14, 1929 and that death occurred, on the date stated above, at 11:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis c decompensation

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) 2 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Physical

(Signed) Lawrence B. Sheldon, M. D.

, 19 (Address) 807 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Nov 16 1929
20 UNDERTAKER	ADDRESS
Mary M Warfield	501 E 22nd St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 50996

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 50996

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 920 N. Collington Ave ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Lowman Keys

(a) RESIDENCE NO. 920 N. Collington Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Rachael E. Keys

6 DATE OF BIRTH (month, day, and year) Aug. 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Rachael Keys

(Address) 920 N. Collington Ave

15 Filed NOV 15 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Nov. 14, 1929, that I last saw h live on Nov. 14, 1929 and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Vincent K. Foster, M. D.

, 19 (Address) 845 N. Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	11/16 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

NOV 15 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 50997

CERTIFICATE OF DEATH

31 E 50997

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 13-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gilbert Clark

(a) RESIDENCE NO. 929 W. 33rd st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 052

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alex Clark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Clark

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M.D. Registrar

NOV 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Nov. 14, 1929, that I last saw him alive on Nov. 14, 1929 and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mus. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Arnold Jr. M. D.

11-15 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side fur additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	11/16 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

All the CAUSE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 50998

1—PLACE OF DEATH

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. 3000 Cresmont Ave ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hortense Marie Scott

(a) RESIDENCE NO. 3000 Cresmont Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard O. Scott

6 DATE OF BIRTH (month, day, and year) April 13, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs T. L. Marshall

(Address) 3000 Cresmont Ave

15 Filed ....., 19 .... Registrar

NOV 15 1929 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 5th, 1929. to Nov 13th, 1929.

that I last saw h alive on Nov 13th, 1929

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pelvis

Involving Urinary Bladder and Intestine

(duration) yrs. 4 mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Sept 17th, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Dr. Geo. A. Cross, M. D.

, 19 (Address) 28 W 25½ St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Nov 15 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

N. B.—WHITE PLAINLY, WITH UNFADING INK. THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 50999
230534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 E 50999

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milborne Keene

(a) RESIDENCE NO. 811 N. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	36	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER W. H. Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Irene (Last name unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 15 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-14-1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1929, to Nov 14, 1929, that I last saw h.im alive on Nov 14, 1929 and that death occurred, on the date stated above, at 8 05 P m.

The CAUSE OF DEATH* was as follows:

Bacteremia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Liver abscess

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 24, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture.

(Signed) Hedwig Kenny, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	Nov 16 1929

20 UNDERTAKER Robert F. Wilson ADDRESS 1515 McCulloh St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51000

CERTIFICATE OF DEATH

74-001 E 51000

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St. Agnes Hospital St., 18-29 (Ward)

2-FULL NAME John M. D. Moss

(a) RESIDENCE NO. 1202 W. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of M. E. D. Moss

6 DATE OF BIRTH (month, day, and year) Jan 22 1855

7 AGE	Years	Months	Days 23	IF LESS than 1 day ..... hrs. or ..... min.
	74	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Police
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Md

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER John D. Moss

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs E. E. D. Moss
(Address)

15 Filed ....., 19.... J. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. J. Brooks, M. D.

Nov 15, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Vernon, Balto. Co.	Nov. 16, 1929
20 UNDERTAKER	ADDRESS
E. Leroy Stiffler, Inc.	125 E. North ave.

NOV 15 1929

Size 2-25-28 I. F. S. 500 Blks

Spec.—2-20-28—L. F. S.—600 Mhs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51001 E 51001

38

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leah Hedgepeth

(a) RESIDENCE NO. 1448 Morton St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

070

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Benjamin Whitey

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M. D.

NOV 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 29 to Nov. 14, 29

that I last saw her alive on Nov. 14, 29

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

" " Coma & exhaustion

(duration) over 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic Fatty

(duration) over 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hist: S.C: W.R.

(Signed) Marion M. McLean, M. D.

11-15, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Raleigh N. C.	Nov 16 1929
20 UNDERTAKER	ADDRESS
Samuel Wemsley	Balto

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks. William Harris

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51002

CERTIFICATE OF DEATH

129 E 51002

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1190 Brepton ST. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Harris

(a) RESIDENCE NO. 1190 Brepton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Cream Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Cream Mfgr.

(c) Name of employer Irvin's. 086

9 BIRTHPLACE (city or town) Richmond

(State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) !

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Edna Harris

(Address) 1190 Brepton St.

15 Filed ....., 19 .....

NOV 15 1929 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13/1929.

17 I HEREBY CERTIFY, That I attended deceased from November 19 29, to November 13 19 29, that I last saw him alive on November 12th 19 29 and that death occurred, on the date stated above, at 10.55 a. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous nephritis

(duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Pennell Fargo, M. D.

11/15, 19 29 (Address) 2937 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	11/16 19 29
20 UNDERTAKER	ADDRESS
Samuel Bowley	578 N. Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is
important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Barbara Brown

E 51003

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51068 B

129

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Brown

(a) RESIDENCE NO. 431 East 23rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 2-3-80

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: Cook

(b) General nature of indostry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Tom

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ann Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 15 1929, 19 ....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov-14-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Nov 14, 1929.

that I last saw her alive on Nov 14, 1929

and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pyelitis Chronic,

(duration) 4 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Urea

(Signed) Louis A Lewis, M. D.

11/14, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	11/16 1929
20 UNDERTAKER	**ADDRESS**
Arnold J Beasley	578 N Bridle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every line must be filled. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51004

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51004

CERTIFICATE OF DEATH

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2291½ Pearl St., 4-25 Ward)

2-FULL NAME Richard Matthews

(a) RESIDENCE NO. 2291½ Pearl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltomd.

PARENTS

10 NAME OF FATHER Frank Matthews

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Josephine Ebb

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Co. Md.

14 Informant Frank Matthews
(Address) Catonsville Md.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollick M. D.

11/15 19 29. (Address) 2737 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Lawn DATE OF BURIAL Nov 16 19 29

20 UNDERTAKER Samuel J. Newsley ADDRESS 78 N Bridle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51005

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

90 E 51005

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 207 Aisquith ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachel Robinson

(a) RESIDENCE NO. 207 N Aisquith ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julius Robinson

6 DATE OF BIRTH (month, day, and year): 1862

7 AGE — Years: 67 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Herman B Robinson

(Address) 1211 N Broadway

15 Filed ..., 19 ... Registrar

NOV 18 1929

G. HAMILTON JONES, M. D.

RAH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-13-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 19 29 to 11-13, 19 29.

that I last saw h[illegible] alive on Nov 13, 19 29

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Renal Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

11-15, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Nov 16 19 29

20 UNDERTAKER: Sam'l H Shriver & Sons

ADDRESS: Fountain Sched

mation should be carefully supplied. AGE should be st
OF DEATH in plain terms, so that it may be properly
important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1294 E 51006

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1328 ander St ST. 24-35 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herman W. Krueger.

(a) RESIDENCE NO. 1328 ander. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Fliznicka Krueger.

6 DATE OF BIRTH (month, day, and year) April 28-1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6.	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Black Diamond Steamship Co

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Herman Krueger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Louise Von Buck.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Anna Krueger

(Address) 1328 ander St

15 Filed NOV 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1929, to Nov. 13, 1928.

that I last saw him alive on Nov 12, 1928

and that death occurred, on the date stated above, at 11:45 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation Decompensated
Chronic Pancreatitis Nephritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Thos F. A. Stevens, M. D.

11/15 1929 (Address) 2818 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville	Nov. 16 1929
20 UNDERTAKER	ADDRESS
Chas R. Thomas	1521 Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 51007

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2003 E Lombard St. 9-4 Ward)

2-FULL NAME Allan J. Sacks

(a) RESIDENCE NO. 2003 E Lombard St., Ward

(Usual place of abode) Unknown.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Unknown

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 60.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown 07
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant John A. Moran
(Address) 3000 E. Balto St.

15 Filed , 19 S. HAMPSON JONES, M. D.
Registrar

NOV 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Octr 1 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary) Gangrene

(duration) yrs. mos. 1 da.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) M. D.

, 19 (Address) 1438 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Nov 15, 1929

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

23 to 91008 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 1001 E 51008

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Herndon

(a) RESIDENCE NO. 518 E. Eager ST., 8th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Car.

PARENTS

10 NAME OF FATHER Walton Herndon

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed NOV 10 1929, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15-29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Nov. 15, 1929.

that I last saw him alive on Nov. 15 1929

and that death occurred, on the date stated above, at 11 20 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of Nov 12, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence Gardner Jr. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Nov 18 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51909 — E 51909

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 27-44 (1929)

CITY OF BALTIMORE: (No. 2903 Southern Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles C. Parker

(a) RESIDENCE NO. 2903 Southern Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Addie Parker

6 DATE OF BIRTH (month, day, and year): July 13, 185[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	70	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mech. Engr.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Richard Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Tomassa Sidressa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): So. America

14 Informant: Addie Parker

(Address): 2903 Southern Ave.

15 Filed NOV 16 1929, 19 — C. HAMPSON JONES, M. D. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1929, to Nov 13th, 1929

that I last saw him alive on Nov 12th, 1929

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & Clinical

(Signed) L. L. Gouth, M. D.

11-13 1929 (Address) 478 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Nov 16 1929

20 UNDERTAKER: John Leerid

ADDRESS: 200 E Oreans

NOTE—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that CAUSE OF DEATH is stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 51010

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

143E 51010

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) University Hospital (St.) 26-27 (Ward)

2-FULL NAME Katherine E Weiss

(a) RESIDENCE NO. 4502 Eastern Ave (St.) 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip S. Weiss

6 DATE OF BIRTH (month, day, and year) May 8- 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	37	6	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Pittroff

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Sauer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Philip Weiss
(Address) 5008 Echo Heights

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Ectopic Pregnancy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Kelly M. D.

11/15. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Nov 18 1929
20 UNDERTAKER Lilly & Zeiler Inc.	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51011 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51011

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Biggs

(a) RESIDENCE NO. 14 S. Broadway ST., 3 WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. Biggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-29

17 I HEREBY CERTIFY, That I attended deceased from 11-13, 1929 to 11-15, 1929 that I last saw him alive on 11-15, 1929 and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchs-Pneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 11-13-29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Fred M. Duckwall, M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Nov 18 1929
20 UNDERTAKER Lilly & Zeiler Inc.	ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

NOV 5 1929 C. HAMILTON JONES, M.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51012

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 51012

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. Balto and ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marion G Schiedt

(a) RESIDENCE NO. 421 N Collington Ave ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late George J. Schiedt

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Francis P. Fay

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York City

12 MAIDEN NAME OF MOTHER Marion Kellar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant Records

(Address) Balto City Hospitals

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-29

17

I HEREBY CERTIFY, That I attended deceased from 6-19-, 1929 to 11-14, 1929

that I last saw her alive on 11-14, 1929

and that death occurred, on the date stated above, at 12.50 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cerebral

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Henry Resident, M. D.

11/14, 1929 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Nov. 18 1929
20 UNDERTAKER Lilly & Gilden Inc.	ADDRESS 403 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

NOV 16 1929 H. C. HAMPSON JONES, M. D. Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51013

CERTIFICATE OF DEATH

E 51013

1-PLACE OF DEATH

City of Baltimore: (No. 666 W. Fairmount ~~Ave~~ St. ~~1223~~ Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elenora Atkins

(a) RESIDENCE NO. 666 W. Fairmount Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. Scott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Seaney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Annie Johnson
(Address) 666 W. Fairmount Ave

15 Filed....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Perinephritic Abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

11/16, 1929. (Address) 2730 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Nov. 17, 1929
20 UNDERTAKER Wm. H. G. Elliott	ADDRESS 1725 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 5101 4

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5101 4

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp 15-22 WARD)

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Turner

(a) RESIDENCE No. 1333 Whatcoat ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Turner

6 DATE OF BIRTH (month, day, and year) Sept 1864

7 AGE Years 45 Months 7 Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Fleming Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Workman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ellen Turner

(Address) 1333 Whatcoat St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 8 , 1929 , to Nov. 14 , 1929 ,

that I last saw h alive on Nov. 14 , 1929

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Toxemia following Intestinal Obstruction

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Nov. 12, '29

Was there an autopsy?

What test confirmed diagnosis? Clinical.

(Signed) J. Castagna , M. D.

, 19 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary DATE OF BURIAL Nov. 16 1929

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1725 Eastlan

D.—NOTE PLAINLY, WITH PENCIL OR PEN, ALL INFORMATION ASKED FOR. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S.,ver.—6-9-19—H. P. Co.—1000 Blks.

E 51015 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51015

CERTIFICATE OF DEATH. 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Gotham Rd St. 15-63 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Edw Gunderodorf.

(a) RESIDENCE. No. 3808 Gotham Rd St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Mrd.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes A Gunderdorf

6 DATE OF BIRTH (month, day, and year) Sept 2 66

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER C Gunderdorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kohlstadt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clark Gunderdorf
(Address) 3808 Gotham Rd

15 Filed NOV 18 1929, 19 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct - 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 22 1929, to Nov 10 1929, that I last saw h alive on Oct - 14 1929, and that death occurred, on the date stated above, at 6:20 p m.

The CAUSE OF DEATH* was as follows: Brain tumor. Surgical Coma.

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Paralysis of Rectum Bladder

Pressure (duration) 1 yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of ?

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Wesley Carr, M. D.

, 19 (Address) 2002 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Nov 18 1929
20 UNDERTAKER	ADDRESS
L M Porter.	2235 Eutaw Pl

NOV 18 1929

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 lbs.

E 51016

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51016

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1876

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 404 N Carrollton ST. (or WARD)

2—FULL NAME John Snowden

(a) RESIDENCE NO. 404 N Carrollton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 year mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Waterbury Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Wm F Strickland

(Address) 404 Carrollton Ave

15 Filed ....., 19 .....

HANSON JONES M

NOV 16 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14-29

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 19 29, to Nov 14, 19 29, that I last saw h alive on Nov 14, 1929 and that death occurred, on the date stated above, at 4 15 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrarted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Geo Dyer, M. D.

Nov 14 1929 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Davisonville Md	Nov 17 1929
20 UNDERTAKER	ADDRESS
H D Baum & Son	1818 W. Mad[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-09 E 51017

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Rutland Ave ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christian Baer

(a) RESIDENCE NO. 1505 Rutland Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if foreign birth 84 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Katherine A. Baer

6 DATE OF BIRTH (month, day, and year) Aug 3/42

7 AGE: Years 87 | Months 3 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): German

PARENTS

10 NAME OF FATHER: Chris Baer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Katherine A. Baer

(Address) 1505 Rutland Ave

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

V 1 6 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14/29

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11 1929 to Nov. 14 1929.

that I last saw him alive on Nov. 14. 1929

and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Arterial Hypertension

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene P. Pennington M. D.

11. 15. 1929 (Address) 514 Stony Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bulls Eau — DATE OF BURIAL: Nov 16 1929

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans St

Information should be carefully supplied. Exact statement of OCCUPATION must be properly classified. Exact statement of DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51018

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51018

CERTIFICATE OF DEATH

1—PLACE OF DEATH South Dak, Front X Fay

REGISTERED NO. 2433

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lola E. Franklin

(a) RESIDENCE NO. Harmon. Ave Co. Md ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Raymond Franklin

6 DATE OF BIRTH (month, day, and year): Oct 10, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 027

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Pikesville. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Raymond Franklin

(Address): Harmon Md

15 Filed ..., 19 ... Registrar

NOV 6 1929 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 11-13-29

17 I HEREBY CERTIFY, That I attended deceased from 11-5, 1929 to 11-13, 1929

that I last saw h[illegible] alive on 11-13, 1929

and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary): post partum eclampsia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis T. Miller, M. D.

, 19 (Address) 1 B Fred. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Md	11 16 1929
20 UNDERTAKER	ADDRESS
J. F. M. Cook	1217 E Fou[illegible] St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 51019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 51019

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 N. Kenwood Ave. ST., (WARD) 47

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie G. Barbolak

(a) RESIDENCE NO. 602 N. Kenwood ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of James Barbolak

6 DATE OF BIRTH (month, day, and year) Nov 1 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Lucas Zubek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Jos. Zubek

(Address) 602 N. Kenwood Ave

15 Filed OCT 1 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-15-29, 19 29, to 11-1-29, 19 29, that I last saw h alive on 11-1-29, 19 29, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Cerebral Arteriosclerosis
Hypertension
(duration) yrs. mos.
Acute Cardiac Decompensation

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No,

What test confirmed diagnosis?

(Signed) [illegible] M.D.

(Address) 602 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	11/4 1929
20 UNDERTAKER	ADDRESS
[illegible]	1906 Eastwood

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 1 1929 C. HAMPSON JONES, M.D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 51020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 E 51020

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin S. Hospital St. 19-28 Ward)

2-FULL NAME Harry J. Findling

(a) RESIDENCE NO. 50 S. Fulton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie A. Findling

6 DATE OF BIRTH (month, day, and year) Aug 23 1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Compositor
(b) General nature of industry, business, or establishment in which employed (or employer) 63
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Harry Findling

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Pflaum

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mary A. Findling
(Address)

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide, Pistol Shot left temp while under Aberration of Mind

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

Nov 16, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	11/16/29
20 UNDERTAKER	ADDRESS
Geo E Stanley Fulton	Loyola

NOV 16 1929

Ward

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5102I

E 5102I

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. 46 328-66

City of BALTIMORE: (No. 4312 Rokeby Road Ward 6)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lulu Waugh Dunning

(a) RESIDENCE NO. 4312 Rokeby Road Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw. E. Dunning

6 DATE OF BIRTH (month, day, and year) September 14 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	67	2 1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) A. A. Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Dr. John W. Dunning

11 BIRTHPLACE OF FATHER (City or town) New York

(State or country)

12 MAIDEN NAME OF MOTHER Margaret A. Dunn

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md

14 Informant Beverly Dunning

(Address) 4312 Rokeby Road

15 Filed NOV 16 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929

Nov 14

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Nov 14, 1929, that I last saw h alive on Nov 14, 1929, and that death occurred, on the date stated above, at 2.05 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C. Smith, M. D.

(Address) 1501 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Olivet Cem	Nov 16, 1929

20 UNDERTAKER Wm. J. Ticket & Son ADDRESS W. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 16 1929

C. HAMPSON JONES

Spec.—1-10-21—M&T—1500 Bks.

E 51022 HEALTH DEPARTMENT—CITY OF BALTIMORE 51022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Md Gen Hosp 161-60

CITY OF BALTIMORE: (No. ..... ST., 26-40 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mackie

(a) RESIDENCE No. Phild Co & Thomas Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-6-29

7 AGE — Years: — Months: — Days: 5 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Baby. old
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: David Donald Mackie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Detroit Mich.

12 MAIDEN NAME OF MOTHER: Charlotte Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt.

14 Informant: Hospital Record
(Address)

15 Filed ..... 19 ..... HAMPSON JONES ..... Registrar
11029
RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6 1929 to Nov 11 1929
that I last saw h[illegible] alive on Nov 11 1929
and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows: Prematurely [7 mos. fetus]

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

11 (Signed) Jno A Symington, M. D.

L.3 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hospital — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 51023

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-60E 51023

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nd Gen Hosp. ST., 2 WARD)

2-FULL NAME Baby Stang

(a) RESIDENCE NO. 813 Hanover Ter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 12 29

7 AGE — Years — Months — Days — If LESS than 1 day, 9 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER John Thomas Stang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jersey City N J

12 MAIDEN NAME OF MOTHER Elizabeth Hamel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant (Address) Hospital Records

15 Filed NOV 16 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 12, 19 29, to Nov 13, 19 29,

that I last saw h[illegible] alive on Nov 13, 19 29,

and that death occurred, on the date stated above, at 3 30 p m.

The CAUSE OF DEATH* was as follows:

Prematurely (6½ mos)

cause undetermined.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

11/14/29 (Signed) Jno A Tompkins, M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hopkh — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

Cor.—10-10-29—A Co.—100 Bks.

E 51024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

182 E 51024

1-PLACE OF DEATH

City of Baltimore: (No. Found floating foot of York St. 27-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Unknown.~~ (C) Robert A. Ball C

(a) RESIDENCE NO. ~~Do not know.~~ 1114 Aisquith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Single ~~Do not know.~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
42 ~~40~~	---------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ~~Do not know.~~ Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ~~Do not know.~~
(State or country) Virginia

PARENTS

10 NAME OF FATHER John Ball C ~~Do not know.~~

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia ~~Do not know.~~

12 MAIDEN NAME OF MOTHER Agnes Coomba C ~~Do not know.~~

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia ~~Do not know.~~

14 Informant Police Report. ~~C. D.~~
(Address) Agnes Ball C mother 1114 Aisquith St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found Floating November 4, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probably accidental.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Fennard, M. D.

11/8, 1929 (Address) 1013 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

Liquor Hospital

NOV 15 1929

THE MORGUE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

388

Cor.—10-10-29—A Co.—100 Bks.

E 51025

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51025

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Harbor Hosp St., 3-t Ward) 18

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mckenna

(a) RESIDENCE NO. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	C	Mckenna

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About 45	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) —
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant .....
(Address)

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1929

17 I HEREBY ~~CERTIFY~~, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

. 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	19
20 UNDERTAKER	ADDRESS

THE MORGUE.

NOV 13 1929

Commissioner of Health.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51026

CERTIFICATE OF DEATH

11-00 E 51026

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 4-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Jones

(a) RESIDENCE NO. 732 Wauseh ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Concrete Mixer

(b) General nature of industry, business, or establishment in which employed (or employer) Laboring 083

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston S. Carolina

PARENTS

10 NAME OF FATHER Robt. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charleston S.C.

12 MAIDEN NAME OF MOTHER Laura Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston S.C.

14 Informant Ida McLean

(Address) 732 Wauseh St.

15 Filed NOV 16 1929, 19 4067 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) nov. 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from 11/9/29, 19, to 11/9, 1929

that I last saw h alive on 11/9, 19 29

and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Perforated gastric ulcer, accompanied by shock.

(duration) yrs. mos. ds. 2hr.

CONTRIBUTORY (Secondary) Surgical shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 732 Wauseh St.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Sur Autopsy

(Signed) W. B. Draper, M. D.

11-15, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS

HAMPSON JONES, M.

NOV 15 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

NOV 16 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51027

CERTIFICATE OF DEATH

129 E 51027

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4 E. Cross ST. 23-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara A. Kohler

(a) RESIDENCE NO. 4 E. Cross ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonhard Kohler

6 DATE OF BIRTH (month, day, and year): Nov. 16 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Leonhard Kohler
(Address) 4 E. Cross St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov 14/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 '28, 19 29, to Nov 14, 19 29, that I last saw h er alive on Nov 13, 19 29 and that death occurred, on the date stated above, at 9-20 a m.

The CAUSE OF DEATH* was as follows:

Chronic int nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis - hypertension

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys + Lab

(Signed) Wm E Stigler M. D.

11/16, 19 29 (Address) 1819 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Nov 17 1929
20 UNDERTAKER	ADDRESS
Margaret L. Flynn	1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

NOV 16 1929

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 28th DAY Apr
OF 1965 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #E 47851 July 23, 1929 AND
ENDING WITH #E 51027 Nov 16, 1929 ARE AC-
CURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: D McFaul

END OF REEL